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ABSTRACT

"Zero to Three" is a single-focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. This issue focuses on the organization's 25 years of working with infants, toddlers, and families. The articles are as follows: (1) "Hope Is a Baby" (Jeree Pawl), on themes of continuity and change related to the well-being and development of infants and toddlers; (2) "Infant and Early Childhood Mental Health: A Comprehensive Developmental Approach to Assessment and Intervention" (Stanley I. Greenspan and Serena Wieder); (3) "A Quarter-Century of the Transactional Model: How Have Things Changed?" (Arnold J. Smeroff and Michael J. MacKenzie); (4) "Thirty Years in Infant Mental Health" (Robert J. Harmon); (5) "Infant-Toddler Child Care in the United States: Where Has It Been? Where Is It Now? Where Is It Going?" (J. Ronald Lally); (6) "Preparing Infant-Family Practitioners: A Work in Progress" (Linda Eggbeer, Tammy Mann, and Linda Gilkerson); (7) "A View of Early Childhood Development" (Irving B. Harris); (8) "The Idea behind IDEA: Creating, Shaping, and Refining Early Intervention Legislation" (Carol Berman and Cindy Oser); and (9) "The Promise of Parents as Advocates" (Bernice Weissbourd and Joan Lombardi). Regular departments of the bulletin list Zero to Three publications, videotapes and on-line resources, and announcements about Zero to Three staff. (HTH)

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2B

Celebrating 25 Years of Working with Infants, Toddlers, and Families

Advances in theory, research, and practice

ZERO TO THREE leaders look back—and forward

Preparing the infant–family work force

Policy achievements and challenges

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Editor's Note

To celebrate the 25th anniversary of ZERO TO THREE, **Jeree Pawl**, my predecessor as Editor of *Zero to Three*, and I decided to invite a sampling of members of the Board of Directors of ZERO TO THREE and several members of the staff to reflect on important areas of the infant–family field. We also asked ZERO TO THREE staff to contribute photos of their children or themselves in the 0–3 years.

Jeree Pawl opens the issue by identifying themes of continuity and change related to the well-being and development of infants and toddlers.

Stanley Greenspan and **Serena Wieder** describe how the "developmental structuralist" theory of emotional development has evolved over 25 years into the developmental-individual difference-relationship (DIR) approach to assessment and intervention.

ZERO TO THREE Board member **Arnold Sameroff**, the creator of the transactional model of development, and his colleague **Michael MacKenzie** remind us of the historical context in which the model was conceived, the enormous re-thinking of assumptions it demanded, and the impact it has had and continues to have in the infant–family field and beyond.

It wasn't easy to convince **Robert J. Harmon** to let us publish the tales from 30 years in infant mental health that so frequently enliven his lectures and speeches. We are glad he said yes; *Zero to Three* readers have much to learn from his stories.

Ron Lally has been "present at the creation" not only of ZERO TO THREE but of infant–toddler child care in the United States. He directs our attention to the subtlest of interactions among infants, caregivers, and parents as well as to the starkest policy choices affecting young children and their families.

Linda Eggbeer, **Tammy Mann**, and **Linda Gilkerson** explore what it takes to prepare practitioners to work effectively in the infant–family field and describe efforts to meet training needs. They pay special attention to the theory and implementation of reflective supervision, one of ZERO TO THREE's most visible contributions to professional development in our field.

The infant–family field as we know it today would not exist without ZERO TO THREE Board Life Member **Irving B. Harris**. The brief excerpts from an oral history interview printed here show why.

Carol Berman and **Cindy Oser** use the Individuals With Disabilities Education Act (IDEA) as a lens through which to view evolving public policy toward infants and toddlers with disabilities and their families, and ZERO TO THREE's growing sophistication and impact in the policy arena.

Bernice Weissbourd and **Joan Lombardi** have been honored many times for their knowledgeable, persistent, passionate advocacy on behalf of family support and high-quality care for infants and toddlers. Here they discuss the promise of parents as advocates — a vision that we hope to see realized sooner rather than later during ZERO TO THREE's next 25 years.

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ZERO TO THREE

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Hope Is a Baby

Jeree Pawl
Editor, Zero to Three, 1985–1992;
President, ZERO TO THREE, 1994–1997

It is not possible to care about children and not care for their parents, families, and all of those whose privilege and responsibility it is to be involved with them — those who can offer children a view and experience of themselves and a world that is promising, engaging, reliable, and joyful. For most of us, nothing represents hope, however elusive, more than a baby. Any baby could be better than we are; any baby might be someone who could right wrongs, see justice done, and be happy doing it.

Our understanding of development in its complex contexts and of the breadth of the necessary, relevant knowledge has grown markedly over the past quarter-century. We owe a great debt of gratitude to the seminal impetus and continuing efforts of infant researchers who study the presence and significance of infants' capacities. They have set a tone of observation, care, imagination, and appreciation of complexity that is now present in many other varied and important areas of inquiry — brain functioning, fetal functioning, the impact of socioeconomic factors on development, cultural relevance, parental mental health, infant and toddler group care, abuse and neglect, and many others. There is almost no area of possible influence on early development that has not captured the interest and effort of someone.

We must also acknowledge the many theorists who have not only pondered the meaning of behavior but have constructed frameworks for thinking about individual and interpersonal dynamics, in more or less inclusive ways. We recognize, as well, those who work in the crucial area of policy — often against great odds and too often with painful disappointment. Their efforts, more often than not, are necessary to make it possible for others to work at all, either as researchers or practitioners. Their determination to enter the fray again and again is as inspiring as it is vital.

It is the goal of all who work in this area to contribute as much as possible to understanding — and providing — those things that are most relevant to an infant or toddler's well-being and good functioning.

Several particularly striking changes over the last 25 years stand out among many others.

- Those who are interested in infants, toddlers, and their families no longer need to prowl the edges of their professions or seek out mavericks to find like-minded colleagues. They are readily available and are to be found centrally located in many different professions. The infant–family field is a large and sprawling family — with all that suggests.
- Most members of the infant–family field are active in fertile areas of close professional overlap and integration. This is a necessity and a boon. The breadth and depth of the sources of overall knowledge relevant to the development of infants and toddlers would overwhelm the ability of any one person to fully master them. The salient and complex expertise overall has grown too vast. Only through mutual awareness, informing, and interdependence can areas of knowledge be integrated. Collaborations within areas of research, within the provision of services, and between them have been truly productive. They range from parents and professionals making observations on site at an inclusive child care center, to a mental health professional sitting hip-to-hip with a judge at a custody hearing, to a team of researchers analyzing both the cortisol content of babies' saliva and the culture of the

Romanian orphanage in which the babies live. Information and inspiration can come from anywhere, but the "anywheres" have to hear each other. Both chaos and order are necessary for this kind of happy crossover. The inclusiveness of this field is truly remarkable.

- The proliferation of programs of all kinds that serve infants, toddlers, and families is stunning. The issues addressed are legion and include the child with some disability; parent–child relationships involving new parents, foster parents, parents with mental disturbance, and grandparents; and any other situation that raises concern for what a child's experience might be. These programs operate at all levels of prevention and intervention. This exponential increase reflects a steadily growing appreciation for the evolving nature of development and the importance of early development. The field has made heroic attempts to provide trainings and workshops for new staff, although program proliferation continues to outrun the very best of efforts.
- There is a growing awareness and appreciation of the salience of the relationships that practitioners and families create. A child care provider appreciates the importance of the way she interacts with each child for the child's good sense of herself; she also understands the value of a partnership with a parent. The occupational therapist revels in having devised with the mother a more successful feeding position with her child, and she values the positive effect on the pair's relationship. She also knows that her positive attitude toward both mother and child carries a lot of meaning and pleasure. But this awareness is not uncomplicated. Most practitioners of whatever background, and they are myriad, have come to appreciate most families holistically. Practitioners' acute awareness of what are, more often than not, a host of compellingly painful needs creates a wish to help families in every way. Not every practitioner has the support that is needed to recognize and weather this wish. A significant challenge accompanies the desirable awareness of the practitioner's awareness that the nature of their relationship with a family can have a potentially significant, positive effect. Too great a focus on relationship, without consistent support, can obscure or conflict with the provider's valuing the service he offers within his area of expertise or intended focus. It may also substantially confuse a practitioner and create an expectation of being able to provide what is essentially a mental health service without needed institutional support and training. This robs practitioners and families of the positive effects that *are* possible with clear understanding and expectations.

We apply our knowledge, and then we wait to be corrected — researcher and practitioner alike.

The few scattered, scrappy programs of 25 years ago have become a new field of practice, training, and research. Increasing our understanding of what can be done to support infants, toddlers, and their families, and what it takes to do it, is simply part of the adventure — an adventure in which a very large group of people is now involved. We need every one of them. As we look toward the future, we must all support sharpening foci, carefully defining selected populations, clearly setting expectations regarding services, and using good process evaluation. Longstanding and new mental health programs of many kinds, focusing on infant–parent mental health, must continuously evaluate how they provide staff and trainees with necessary theoretical structure (and there are many different ones being successfully used), technical skills, and crucial supervision. The pressure for more programs, more practitioners, and more training will be ongoing, and we will be glad. We will worry about the programs that do not get help and those that do not even know to ask for help. Finally, the coming together of so many varied (and necessarily varied) bodies of knowledge into this inclusive area of interest in infants, toddlers, and their families cannot help but confirm the wonderful specialness and uniqueness of each human being. We also need every one of them. There is just not another single one like any other.

Every new discovery in infant–family research and practice helps us understand more about development and its myriad internal and external, mutually influencing contributors. But each new discovery also teaches us that we can neither know fully nor predict the beautiful, puzzling, and astonishing aspects of the behavior of even one single human being. We elude, and we are private.

We apply our knowledge, and then we wait to be corrected — researcher and practitioner alike. When we work directly with families we wait to be corrected again and again as we are led by this baby, by this parent, and by this family into the creation of their own particular ways of being — ways that are sometimes, with our help, much for the better.

Now, who would have it any other way?

Infant and Early Childhood Mental Health:

A Comprehensive Developmental Approach to Assessment and Intervention

Stanley I. Greenspan
George Washington University Medical School
Bethesda, Maryland
and
Serena Wieder
Interdisciplinary Council on Developmental and Learning Disorders
Silver Spring, Maryland

The field of infant and early childhood mental health has been built on an impressive foundation. It includes studies on early emotional development by Spitz, Bowlby, Murphy, Anna Freud, and Erikson; studies on individual differences by Brazelton, Ayres, Murphy, and Escalona; and studies on caregiver and family dynamics and early intervention by Provence and Fraiberg. (See the suggested readings list, Group A.) It also includes a relatively modern literature on normative emotional development, psychopathology in infants and young children, and preventive and early intervention, by Ainsworth, Emde, Sroufe, Stern, Greenspan, Lourie, and Wieder, among others. (See the suggested readings list, Group B.)

Even with such pioneers leading the way, it has remained a challenge to map completely the development of emotions and cognition and their relationship. It is also difficult to construct a truly comprehensive, developmental approach to intervention, one that takes into account all aspects of the infant's life, including individual "processing" differences, developmental abilities, interactive patterns, and caregiver, family, cultural, and community dynamics. In the early 1970s, we had an opportunity to address this challenge. Joined by Reginald Lourie, we developed the Clinical Infant Development Program (CIDP) at the National Institute of Mental Health. CIDP was a comprehensive assessment and

at a glance

- ZERO TO THREE and the Interdisciplinary Council for Developmental and Learning Disorders (ICDL) trace their roots to the Clinical Infant Development Program of NIMH.
- In the Developmental, Individual-Difference, Relationship-Based model, "D" stands for functional, emotional developmental capacities; "I" refers to individual differences, and "R" describes the child's relationships with caregivers and culture.
- The DIR model of intervention (sometimes referred to as Floor Time) includes direct work with the child, work with parents and caregivers, and work with caregiver and family patterns.

intervention program for infants and families with or at risk for a variety of developmental and emotional challenges. With the help of an advisory group that initially included Berry Brazelton, Selma Fraiberg, Sally Provence, Albert Solnit, and Peter Neubauer, we observed and charted children's early emotional milestones (in both healthy and pathologic forms), motor and cognitive processing differences, and infant–caregiver and family interaction patterns. On the basis of our observations, we constructed a comprehensive approach to assessment, diagnosis, and intervention.

In 1977, the CIDP "gave birth" to ZERO TO THREE: National Center for Infants, Toddlers, and Families and, more recently, to the Interdisciplinary Council for Developmental and Learning Disorders (ICDL). Our work at CIDP laid much of the foundation for ZERO TO THREE's *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3; ZERO TO THREE, 1994), and ICDL's *Clinical Practice Guidelines* (Interdisciplinary Council on Developmental and Learning Disorders Clinical Practice Guidelines Workgroup, 2000; see www.zerotothree.org and www.icdl.com).

With further clinical experience, we have been able to refine this comprehensive developmental approach for infants and young children and their families with mental health challenges (Greenspan & Lourie, 1981, 1987; Greenspan & Wieder, 1999).

Suggested Readings

Group A

Ayres, J. A. (1964). Tactile functions: Their relation to hyperactive and perceptual motor behavior. *American Journal of Occupational Therapy, 18,* 6–11.

Bowlby, J. (1951). *Maternal care and mental health* (WHO Monograph No. 2). Geneva: World Health Organization.

Brazelton, T. B., & Nugent, J. K. (1995). *The neonatal behavioral assessment scale.* Cambridge, MA: Mac Keith Press.

Erikson, E. H. (1950). *Childhood and society.* New York: W. W. Norton.

Escalona, S. (1968). *The roots of individuality.* Chicago: Aldine.

Fraiberg, S. H., Adelson, E., & Shapiro, V. (1987). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In L. Fraiberg (Ed.), *Selected writings of Selma Fraiberg* (pp. 100–136). Columbus: Ohio State University Press.

Freud, A. (1965). *Normality and pathology in childhood: Assessments of development.* New York: International Universities Press.

Murphy, L. (1974). *The individual child.* (Department of Health, Education, and Welfare, Publication No. OCD 74-1032) Washington, DC: Government Printing Office.

Provence, S. (Ed.). (1983). *Clinical infant reports: No 2. Infants and parents: Clinical case reports.* New York: International Universities Press.

Spitz, R. A. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *The Psychoanalytic Study of the Child 1,* 53–74.

Group B

Ainsworth, M., Bell, S. M., & Stayton, D. (1974). Infant–mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M. Richards (Ed.), *The integration of the child into a social world* (pp. 99–135). Cambridge: Cambridge University Press.

Emde, R. N., Gaensbauer, T. J., & Harmon, R. J. (1976). *Emotional expression in infancy: A biobehavioral study* (Psychological Issues Monograph No. 37). New York: International Universities Press.

Sroufe, L. A. (1979). Socioemotional development. In J. Osofsky (Ed.), *Handbook of Infant Development* (pp. 462–516). New York: Wiley.

Stern, D. (1974). Mother and infant at play: The dyadic interaction involving facial, vocal, and gaze behaviors. In M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver* (pp. 187–213). New York: Wiley.

Greenspan, S. I. (1979). *Intelligence and adaptation: An integration of psychoanalytic and Piagetian developmental psychology.* (Psychological Issues Monograph No. 47 and 48). New York: International Universities Press.

Greenspan, S. I. (1989). *The development of the ego: Implications for personality theory, psychopathology, and the psychotherapeutic process.* New York: International Universities Press.

Greenspan, S. I., & Lourie, R. S. (1981). Developmental structuralist approach to the classification of adaptive and pathologic personality organizations: Infancy and early childhood. *American Journal of Psychiatry, 138,* 725–735.

Greenspan, S. I., & Wieder, S. (1997). Developmental patterns and outcomes in infants and children with disorders in relating and communicating: A chart review of 200 cases of children with autistic spectrum diagnoses. *Journal of Developmental and Learning Disorders, 1,* 87–141.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth.* Reading, MA: Perseus Books.

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The Developmental, Individual-Difference, Relationship-Based (DIR™) Model

Our comprehensive developmental approach to assessment and intervention involves three dynamically related influences. These influences work together to direct human development.

The first influence is the biological and genetic makeup that the child brings into the world. This includes relative strengths or weaknesses in processing capacities in the areas of auditory processing and language, visual-spatial processing, motor planning and sequencing, and sensory and affective modulation, as well as other cognitive, motor, or sensory processes. A child's processing capacities mediate the way a child interacts with those around him.

A second influence, which includes cultural, environmental, and family factors, helps to shape the thoughts, behaviors, and ideas that the child's caregivers or others in his environment bring to their interactions with him.

The third influence is the patterns of interaction between a child and caregiver, which are the result of how the child's biology and environment work together. These interaction patterns, in turn, determine the extent to which a child masters or fails to master a number of core functional emotional developmental capacities or stages. These capacities include self-regulation, relating, preverbal affective reciprocity, and the formation of symbols.

Understanding how biologically based processing differences and family–caregiver patterns influence each core functional emotional developmental capacity has allowed us to describe the developmental pathways that lead to mental health or to various disorders. This understanding has also helped us to discover methods of early identification and intervention that can help an infant return to an adaptive developmental pathway before problems become chronic. A recent study by the federal government's National Center for Health Statistics of more than 15,000 families showed that including items about functional emotional developmental capacities in a health survey led to the identification of approximately 30% more infants at risk than were identified by earlier surveys, which asked only about developmental or emotional problems. Most of these children were not receiving services (Simpson, Colpe, & Greenspan, 2003).

We have termed our approach to assessing and understanding the role of all these different factors in the development of infants and young children the Developmental, Individual-Difference, Relationship-Based model. In this model, *D* stands for the functional, emotional developmental capacities the child needs to master; *I* refers to individual differences, which are the expression of the child's unique biology (genetic, constitutional, and maturational components); and *R* describes the child's relationship with caregivers, family members, and the larger culture.

The goal of the assessment is to understand as much as possible about *D*, *I*, and *R*. This understanding sets the stage for intervention, where the strategy is to tailor interactions with the child, including therapeutic interactions, to the child's individual processing differences (i.e., his or her unique biology). The goal is to facilitate mastery of each of the core functional emotional developmental capacities (e.g., engagement, affect signaling, and symbol formation). Using this model, a clinician can help children and families deal with and overcome emotional and cognitive lags, constrictions, and deficits—as well as associated symptoms—and foster adaptive development.

Using the DIR Approach in Assessment

As indicated, the DIR model examines the developmental capacities of children in the context of their unique, biologically based processing profiles and their family relationships and interactive patterns. Assessments begin with discussions and observations. An assessment includes:

1. Two or more 45-minute-long clinical observations of child–caregiver interactions, clinician–child interactions, or both;
2. A review of the child's developmental history and current functioning in terms of the functional emotional developmental levels to be achieved;
3. A review of family and caregiver functioning;
4. A review of current intervention programs and patterns of interaction;
5. Consultation with speech pathologists, occupational and physical therapists, educators, and mental health colleagues; administration of structured tests on an as-needed, rather than routine basis; and
6. Biomedical evaluation.

Using these tools, the clinician can begin to uncover a unique profile of functioning, in many areas, that can inform a developmentally appropriate intervention plan.

This comprehensive, developmental model (DIR) assesses the following areas.

Functional Emotional Developmental Levels. The infant or young child's functional emotional developmental level reveals how the child uses everyday functioning to integrate all capacities (social, motor, cognitive, language, spatial, and sensory) to carry out emotionally meaningful (i.e., functional) goals. Evidence for the existence of functional emotional developmental levels is reviewed elsewhere (see Greenspan, 1979, 1989, 1992, 1997, 2002; Greenspan, DeGangi, & Wieder, 2001; Wieder & Greenspan, 2001). Functional capacities include the ability to

1. Attend to multisensory affective experience and, at the same time, organize a calm, regulated state (e.g., looking at, listening to, and following the movement of a caregiver);
2. Engage with and display preference and affection toward a familiar caregiver or caregivers (e.g., joyful smiles to a consistently available caregiver);
3. Initiate and respond to two-way presymbolic gestural

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communication (e.g., back-and-forth use of smiles and sounds);

4. Organize chains of two-way social problem-solving communications (opening and closing many circles of communication in a row), maintain communication across space, integrate affective polarities, and synthesize an emerging prerepresentational organization of self and other (e.g., taking Dad by the hand to get a toy on the shelf);
5. Create and use ideas as a basis for creative or imaginative thinking, giving meaning to symbols (e.g., pretend play, using words—"Juice!"—to meet needs); and
6. Build bridges between ideas as a basis for logic, reality testing, thinking, and judgment (e.g., engage in debates; opinion-oriented conversations; elaborate, planned pretend dramas; or all three).

Individual Differences in Sensory, Modulation, Processing, and Motor Planning. Biologically based individual differences are the result of genetic, prenatal, perinatal, and maturational variations. Individual differences can be observed in infants' and young children's

- Sensory modulation, including hypo- and hyperreactivity in each sensory modality, including touch, sound, smell, vision, and movement in space;
- Sensory processing in each sensory modality, including auditory processing and language and visual-spatial processing (processing includes the capacity to register, decode, and comprehend sequences and abstract patterns);
- Sensory-affective processing in each modality (e.g., the ability to process and react to affect, including the capacity to connect "intent" or affect to motor planning and sequencing, language, and symbols)—this processing capacity may be especially compromised in autistic spectrum disorders (Greenspan & Wieder, 1998); and
- Motor planning and sequencing, including the capacity to sequence actions, behaviors, and symbols, including symbols in the form of thoughts, words, visual images, and spatial concepts.

Relationships and Interactions. The interaction patterns between the child and caregivers and family members bring the child's biology into the larger developmental progression and can contribute to the negotiation of the child's functional developmental capacities. Developmentally appropriate interactions mobilize the child's intentions and affects. They broaden the child's range of experience at each level of development, helping the child move from one functional developmental level to the next. In contrast, interactions that ignore or fail to match the child's functional developmental level or individual differences can undermine progress. For example, a caregiver who is aloof may not be able to engage an underreactive, self-absorbed infant in mastering even the most basic functional developmental levels.

The Functional Developmental Profile

The DIR assessment leads to an individualized functional profile that captures the child's unique developmental features and serves as a basis for creating individualized intervention programs (i.e., tailoring the program to the child rather than fitting the child to a general program). The profile describes the child's functional emotional developmental capacities, as uncovered in the assessment; contributing biological processing differences; and environmental interactive patterns, including the different interaction patterns available to the child at home, at school, with peers,

and in other settings. The profile should include all areas of challenge, not simply the ones that are more obviously associated with symptoms of one or another syndrome or disease. For example, a preschooler's lack of ability to symbolize a broad range of emotional interests and themes in either pretend play or talk is just as important, if not more important, than that child's tendency to be perseverative or self-stimulatory. Clinically we have often seen that as the child's range of affective and symbolic expression broadens, perseverative and self-stimulatory tendencies decrease.

Creating a functional developmental profile enables the clinician to consider each functional challenge separately, explore alternative explanations for the challenge, and resist the temptation to assume that difficulties are necessarily tied together as part of a syndrome (unless all alternative explanations have been ruled out). For example, aggression may be related to sensory underreactivity and sensory craving, coupled with punitive, unavailable caregiving. Hand flapping may be related to motor or sensory challenges: This behavior is not uncommon when children with a variety of motor or sensory challenges become excited or overloaded.

Selma Fraiberg, Sally Provence, Lois Murphy, Sibylle Escalona, and T. Berry Brazelton, among others, laid the foundation for a comprehensive developmental approach to intervention.

A special feature of the DIR profile is its focus on early presymbolic levels of functioning. Presymbolic levels often involve basic capacities such as self-regulation and engagement, reciprocating emotional gestures, and forming a sense of self. In each area of the profile, one looks for competencies as well as deficits (where a child has not achieved expected levels). One also looks for constrictions (where an ability is present but not at its full, robust, and stable form). Constrictions may involve a narrowing of the thematic or affective range (e.g., a child shows only pleasure, no anger); a lack of stability (e.g., the child can engage, but loses this capacity and becomes self-absorbed when anxious); or a lack of motor, sensory, cognitive, or language support for a particular capacity (e.g., the child can be assertive with words, but not with motor patterns).

A Developmental Model for Intervention

A number of pioneering interventions laid the foundation for a comprehensive developmental approach. These included Selma Fraiberg's work on caregiver perceptions and misperceptions of their infants; Sally Provence's work on family support and social development; Murphy, Escalona, and Brazelton's work on individual differences; and a number of intervention research projects that studied the effect of early educational enrichment and family support (e.g., the Carolina Abecedarian Project, the Syracuse University Family Development Research Program [Lally, Mangione, Honig, & Wittmer, 1988], the Perry Preschool Project [Schweinhart, Barnes, & Weikart, 1993], and the Elmira Prenatal/Early Infancy Project [Olds et al., 1997]).

Building on these foundations, which focused on one or several areas of emotional interaction and development, we created a comprehensive model for intervention that included a systematic approach to the core areas and different levels of emotional functioning; the main motor, sensory, and cognitive processing capacities; caregiver and family interaction patterns; and the relationships between them. This model was initially implemented in our NIMH Clinical Infant Development Program (Greenspan et al., 1987) and has been extended to clinical work with children with autistic spectrum and other emotional, developmental, and learning disorders through regional networks and regional councils of the Interdisciplinary Council for Developmental and Learning Disorders (Greenspan, 1992; Greenspan & Wieder, 1998). The features of this model include

1. Opportunities to enable the child to master the basic functional emotional developmental capacities described earlier;
2. Support for stable and broad-ranging mastery of these capacities, for example, the child may have mastered two-way communication in terms of dependency but not assertiveness, curiosity, or aggression—we try to help a child master a developmental capacity thoroughly, so that the capacity tends to survive even under stressors such as a mild physical ailment, a brief separation from a parent, or a strong feeling;
3. Attention to contributing factors, including the constitutional and maturational, motor, sensory, cognitive, and social processing aspects of the child's development and the interactive and family aspects of the child's experience; and
4. Ongoing relationships (with caregivers, therapists, and educators) that foster 1, 2, and 3 above.

Consider, for example, a young child who seems to have problems with attachment. In the DIR model, the clinician would consider the situation not only from the perspective of the caregiver–infant relationship and the caregivers' and family's feelings and interactive patterns but also in the context of the infant's individual processing differences, such as sensory underreactivity and motor planning problems. Infants with attachment difficulties may be sensory underreactive and experience low muscle tone and motor-planning challenges in addition to problematic caregiver–infant interaction patterns and overall family functioning. All these factors may intensify one another. For example, a mother may feel a sense of failure because her underreactive infant is "hard to engage." As a result, she may withdraw from the baby and become more and more depressed. In

such a context, the clinician may choose to work directly on strengthening the infant's sensory modulation and motor capacities while working with the interactive and caregiver and family dynamics. Similarly, challenges that are often thought to be predominantly physical in nature, such as a motor delay, require attention to the caregiver's feelings and the family patterns. Autistic spectrum disorders require attention to all these factors.

The DIR model is a systematic, comprehensive approach to attending to all the factors that are affecting a child's functional development and integrating an individualized intervention program to help the child thoroughly master developmental capacities. We have been able to use the model to facilitate development in children with a variety of problems ranging from autistic spectrum disorders to circumscribed regulatory and emotional challenges, such as aggression, distractibility, depression, and sleep and eating problems (Greenspan, 1992; Greenspan & Wieder, 1998, 1999; www.icdl.com). The next section will take a closer look at these processes.

We have used the DIR model to facilitate development in children with problems ranging from autistic spectrum disorders to circumscribed regulatory and emotional challenges, such as aggression, distractibility, depression, and sleep and eating problems.

Direct Work With the Child. Traditionally, direct work with very young children has included imaginative play, putting feelings into words, attempting to resolve conflicts, employing behavioral principles, and advising parents to behave in certain ways with their children. These approaches seldom deal adequately with all functional emotional developmental levels, including the child's preverbal levels of interaction or the child's individual motor and sensory processing differences.

The DIR model (sometimes referred to as Floor Time) uses a developmental approach to working directly with the child. This approach harnesses the infant's and young child's core functional emotional developmental competencies, including capacities for attention and engagement, two-way communication, representing experience (if the child is 18 months of age or older), and differentiating experience (if the child is over 2.5 or 3 years of age). As its name suggests, Floor Time involves literally getting down on the floor with the youngster and engaging him by following his lead in what interests him in such a way as to mobilize the different functional emotional developmental levels. With a preverbal infant or very young child, one woos her into a rhythm of reciprocal interaction, using facial expressions and gestures to pull the child in. A comprehensive, developmental DIR intervention program may involve parents, educators, and therapists, all of whom engage the child in this way.

Involving parents in direct work with the child is one of the first, and certainly one of the most important, goals of the DIR model. In general, we recommend that parents engage their child in unstructured, interactive or pretend play Floor Time sessions that are 20 to 30 minutes or longer a number of times each day, the number and length depending on the child's developmental needs. For children 3 years of age and older, we recommend an additional daily session or sessions that are designed to help the child learn to discuss "reality" issues and anticipate situations, attendant feelings, and possible problem-solving strategies.

The DIR profile may indicate that the child needs direct, one-on-one psychotherapy in addition to Floor Time with parents and other family members. The therapist should build his psychotherapeutic efforts on the *D* (functional, emotional, developmental level), *I* (individual differences), and *R* (relating and relationships) of the DIR model discussed earlier, incorporating the principles of Floor Time described above. The therapist's direct work with the child should supplement the Floor Time the parents do with their child.

The clinician can help the parents to figure out how to engage the child at each of the functional developmental levels and to deal with the child's individual processing differences. Furthermore, the therapist helps the parents assist the child to apply each of these developmental capacities to a broad range of human emotions—pleasure, dependency, excitement, assertiveness, aggression, self-limit-setting, empathy, and more mature types of love.

The therapist uses his emotional interactions with the child to strengthen the functional emotional developmental capacities up to the highest one the child has achieved, broaden the child's emotional range, and strengthen processing capacities. This process enables the therapist to help the child who is avoidant, overly reactive, has difficulty remaining focused, becomes easily agitated, tends to withdraw, becomes paralyzed with anxiety, has overwhelming fears, or becomes fragmented and lost in fantasy.

The clinician also works with the child's individual processing differences. For example, he will be especially soothing and regulating for the hypersensitive child, energizing for the sensory underreactive child, and supportive of the child's motor and visual–spatial worlds for the child with motor planning and visual–spatial processing challenges.

The therapist will want to coach himself in much the same way he coaches the parents, paying attention to his own tactics, asking himself, for example, "How am I trying to simplify my gestures or words for this child with an auditory processing difficulty?" He will also want to pay attention to his own emotional reactions: "Why do I get so bored and avoidant when Johnny tunes me out or becomes repetitive in his play?" The therapist may conduct his direct work either with the parent or parents present, alone with the child, or in both ways, depending on the clinical needs of the case.

The ongoing intervention is also an ongoing assessment. The clinician who initially observes the parents and his own interactions with the infant or child to formulate his initial diagnostic impression should continually revisit impressions, diagnosis, and treatment goals as he learns from his therapeutic experiences with child and family.

Work With Parents and Caregivers. The DIR model encompasses two broad categories of work with parents and caregivers. The first involves coaching parents concerning Floor Time activities with the child. The clinician may suggest that the parents try various approaches, or may actually go through the steps of Floor Time with them. Alternatively, the clinician may model Floor Time techniques with the child for the parents to observe. We have found that one of the best ways of coaching is to get down on the floor with the parents, sometimes whispering suggestions into their ears, sometimes wondering aloud why they are trying something one way rather than another and exploring their feelings, and sometimes providing a few ideas that the parents can use to discover how it feels to engage their child in a new way. The key to effective work with parents, generally, is to capture their attention, engage them, interact with gestures and expressions, and help them reflect on how and why they interact with their child in a certain way.

One of the best ways of coaching is to get down on the floor with parents.

A second facet of consulting involves working with the parents' or caregivers' own difficulties in interacting with the child. One might assume that most parents would have an intuitive ability to interact with their children in ways that help them master functional developmental levels. This is not always the case. When parenting ability does not come naturally, there is usually a good reason. Perhaps the parents were never engaged in this way as children and so did not have a chance to learn these techniques; the parents may be conflicted about one or another of the developmental processes or about applying them to the different emotional realms; or there may be family challenges, such as marital conflicts, depression, substance abuse in a caregiver, or problems with another child. The clinician will discover over time which, if any, of these factors are operating.

Therefore, in addition to her educational, coaching role, which needs to be handled with respect for the parents' need for active mastery and discovery, the clinician needs to be aware of the parents' underlying feelings and challenges. Part of her job, in this regard, is to clarify for the parents how these feelings influence their interaction with the child. Such clarification may be achieved "on the floor" during work with the child or in sessions with the parents alone, when they can feel freer to discuss their reactions to the child's Floor Time.

Parents' conflicts and anxieties will often play themselves out in their interactions with the child. A parent who is anxious about aggression, for example, is less likely to be able to help a child with aggression than a parent who is comfortable with it. However, parents who are motivated by warmth and concern and who have the potential for growth can be mobilized by their desire to assist their children. Parents grow emotionally alongside their children.

Work With Caregiver and Family Patterns. To help parents make the best use of Floor Time processes, the clinician must observe how family patterns have joined with other factors to contribute to the child's current functioning. For example, in a certain family, does the father's avoidance and the mother's "making nice-nice" with regard to the child's aggression interfere with their own relationship? Is the mother frustrated with the father's avoidance? Is the father frustrated with her tendency to "make nice-nice?" How does this process affect the other children in the family?

The therapist must avoid becoming fragmented or lost in the family's patterns so that he can help the parents understand and work with those patterns. For example, when individual differences in the child, such as sensitivities to sound or touch or tendencies toward motor discharge, have made it difficult for the parents or caregivers to engage the child, parent consultation sessions can often help the family to recognize the reality of the child's sensitivities or motor difficulties without distortions or projections. The degree of family difficulties will determine the length of time required to address family patterns.

When a family appears very disorganized, a clinician may be tempted to discount them to work with the child alone. This would be a mistake. One may spend the first year simply working toward consistent engagement and two-way communication among family members without much progress occurring in symbolizing complicated feelings or seeing connections between feelings. Even this accomplishment, however, provides a strong foundation, especially if the child does not have the rug pulled out from under him by disengagement or random and chaotic communication patterns. Over time, as a foundation of engagement and simple two-way communication is established, the family's ability to symbolize and categorize complex emotions will gradually grow (Greenspan et al., 1987).

Using DIR With a Range of Clinical Challenges. We have applied the DIR model for infant and early childhood mental health to a wide range of clinical challenges, including

1. Interactive disorders, such as problems with attachment, anxiety and fear, and depression;
2. Regulatory disorders, in which significant processing differences, such as sensory over- or underreactivity, motor planning problems, or visual-spatial processing problems contribute to attentional, sleep, impulse control, and language or learning problems; and
3. Disorders of relating and communicating, in which multiple processing challenges derail the

core functional emotional developmental capacities, such as engaging and relating, reciprocal emotional gesturing, and symbol formation.

This last category includes syndromes such as Autistic Spectrum Disorders, Multisystem Developmental Disorders, and severe deprivation reactions, as seen in children from poorly run orphanages or families facing multiple, severe challenges. (For a further description of these categories and a discussion of assessment and therapeutic approaches, see Greenspan et al., 1987; ZERO TO THREE, 1994; Greenspan & Wieder, 1998.)

Conclusion

The DIR model builds on a considerable foundation of infant and early childhood research. It provides a comprehensive, developmental approach that works with the child's functional emotional developmental capacities, the child's biologically based individual processing differences, and the child's relationships with his parents and caregivers, as well as the larger context of his family and culture. It guides both assessments and interventions and enables parents to facilitate the emotional and cognitive growth of their infants and young children, even when there are significant problems. The goal of the DIR model is not merely to help the child overcome presenting problems but, rather, to make it possible for the child to return to an adaptive developmental pathway.

REFERENCES

Greenspan, S. I. (1979). *Intelligence and adaptation: An integration of psychoanalytic and Piagetian developmental psychology* (Psychological Issues Monographs 47 & 48). New York: International Universities Press.

Greenspan, S. I. (1989). *Development of the ego: Implications for personality theory, psychopathology, and the psychotherapeutic process*. Madison, CT: International Universities Press.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges*. Madison, CT: International Universities Press.

Greenspan, S. I. (1997). *The growth of the mind and the endangered origins of intelligence*. Reading, MA: Addison Wesley.

Greenspan, S. I. (2002). *The secure child: Helping our children feel safe and confident in an insecure world*. Cambridge, MA: Perseus Books.

Greenspan, S. I., DeGangi, G. A., & Wieder, S. (2001). *The functional emotional assessment scale (FEAS) for infancy and early childhood: Clinical & research applications*. Bethesda, MD: Interdisciplinary Council for Developmental and Learning Disorders.

Greenspan, S. I., & Lourie, R. S. (1981). Developmental structuralist approach to the classification of adaptive and pathologic personality organizations: Application to infancy and early childhood. *American Journal of Psychiatry, 138*(6), 725–735.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs: Encouraging intellectual and emotional growth*. Reading, MA: Perseus Books.

Greenspan, S. I., & Wieder, S. (1999). A functional developmental approach to autism spectrum disorders. *Journal of the Association for Persons with Severe Handicaps, 24*(3), 147–161.

Greenspan, S. I., Wieder, S., Lieberman, A., Nover, R., Lourie, R., & Robinson, M. (1987). Infants in multirisk families: Case studies in preventive intervention. *Clinical Infant Reports, No. 3*. New York: International Universities Press.

Interdisciplinary Council on Developmental and Learning Disorders Clinical Practice Guidelines Workgroup (2000). *Interdisciplinary Council on Developmental and Learning Disorders' Clinical practice guidelines: Redefining the standards of care for infants, children, and families with special needs*. Bethesda, MD: Author.

Lally, J. R., Mangione, P. L., Honig, A. S., & Wittmer, D. S. (1988). More pride, less delinquency: Findings from the ten-year follow-up study of the Syracuse University Family Development Research Program. *Zero to Three, 8*(4), 13–18.

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *Journal of the American Medical Association, 278*, 637–643.

Schweinhart, L. J., Barnes, H. V., & Weikart, D. P. (1993). *Significant benefits: The High/Scope Perry Preschool study through age 27*. (Monographs of the High/Scope Educational Research Foundation No. 10). Ypsilanti, MI: High/Scope Press.

Simpson, G., Colpe, L., & Greenspan, S. (2003). Measuring functional developmental delay in infants and young children: Prevalence rates from the NHIS-D. *Paediatric and Perinatal Epidemiology, 17*, 68–80.

Wieder, S., & Greenspan, S. I. (2001). The DIR (Developmental, Individual-difference, Relationship-based) approach to assessment and intervention planning. *Zero to Three, 21*(4), 1–19.

ZERO TO THREE (1994). Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Washington, DC: Author.

A Quarter-Century of the Transactional Model:

How Have Things Changed?

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It is very hard to change people's minds. Few people change their opinion when they confront an opposing argument that is only somewhat better than their own. More people change when their beliefs lead to obvious contradictions. Such was the case when Arnold Sameroff and Michael Chandler published a review of child development research in 1975, entitled "Reproductive Risk and the Continuum of Caretaking Casualty." The article altered the thinking of many developmental scientists at two levels—the practical and the theoretical. Eventually, the article was selected as one of the 20 studies that revolutionized child psychology (Dixon, 2002). Practically, the article identified the contradiction between the belief that early abnormalities of the brain were the explanation for a variety of mental health and learning difficulties and the evidence that most infants with these abnormalities grew up to be normal children and adults. Theoretically, the article exposed the contradiction between the belief that nature *or* nurture predicted developmental outcomes and the evidence that nature and nurture were really inseparable.

For most of the 20th century, developmental scientists had presumed that perinatal physical problems had powerful effects on children's cognitive and social emotional development. Because researchers found linkages between obvious infant brain damage and later cognitive and mental health problems, they came to believe that almost any such developmental problem must be the result of brain damage. As a consequence of this strong belief, when scientists could not detect evidence of an injury in a child with a developmental problem, they proposed that there must be undetectable "minimal brain damage" resulting from pregnancy and birth complications (Pasamanick & Knobloch, 1961). If a child developed cognitive or social and emotional problems, scientists were certain that some brain injury must have

at a glance

- For most of the 20th century, researchers believed that if a child developed cognitive, social, or emotional problems, some brain injury must have occurred.
- Later, scientists found that babies with birth problems were likely to have developmental problems only if they were raised in a high risk family.
- In the transactional model of development, child outcomes are a product of the combination of an individual and his or her experience.
- Converging evidence for the existence of bi-directional, reciprocal relationships between infants and their caregivers provides a strong basis for effective intervention.

ISABELLA FINKEN

occurred. They failed to consider alternative explanations of why children developed such problems.

The deterministic belief that brain problems led to developmental problems was based on research that compared individuals with various learning and mental health difficulties with people who did not have such problems. In each study, the group with developmental problems had a higher percentage of birth and pregnancy complications. The problem with this research was that it was retrospective. In other words, scientists identified children or adults with problems and then looked back at their histories to find out whether there was anything that distinguished them from people without these problems. This is a good strategy for identifying possible causes but not a good one for proving the connection between cause and effect. To test whether a hypothesized cause produces a predicted effect requires prospective research.

In prospective research, scientists begin their study with babies, dividing them into groups with and without birth complications. Scientists then follow these infants until they become schoolchildren or adults and test them to see whether there are more developmental problems in the birth-complication group. A number of such studies found that among children raised in poverty by parents with limited education, there were differences in outcome between children with and children without birth complications (Wilson, 1985; Fawer, Besnier, Forcada, Buclin, & Calame, 1995). To everyone's surprise, however, there were no differences between groups of children raised in more affluent families. The "undetected" brain damage thought to be associated with birth complications could not be producing learning and mental health problems by itself, because in high socioeconomic status families, on average, groups of children who did and did not have birth complications developed the same.

Simply put, babies with birth problems were likely to have developmental problems only if they were raised in a high-risk family. This is the kind of contradiction that can lead people to change their minds. What had appeared to be an exclusively medical problem now became a social problem as well. To understand children's mental well-being now required paying attention to the conditions in which they were raised. This idea fit well with the spirit of the 1970s, when social justice was a dominant theme in the national consciousness.

An example of these results comes from the now-famous Kauai study of all the children who were born on that island during a single year (Werner, Bierman, & French, 1971), eventually following them prospectively for over 30 years (Werner & Smith, 2001). By age 10, 34% of the children had some recognizable physical, intellectual, or behavior problem, but only a minor proportion of these problems could be attributed to perinatal difficulties. Werner and her colleagues concluded that 10 times as many children had problems related to poor environments than to the effects of birth and pregnancy complications.

This is not to say that perinatal problems cannot lead to developmental problems. What Sameroff and Chandler proposed in 1975 was that an automatic belief in the power of biological determinism was not justified. A more complicated way of thinking about development was necessary. Sameroff and Chandler presented this more complex point

of view as a transactional model of development, which combines influences of the child's biological heritage and life experience in a dynamic system.

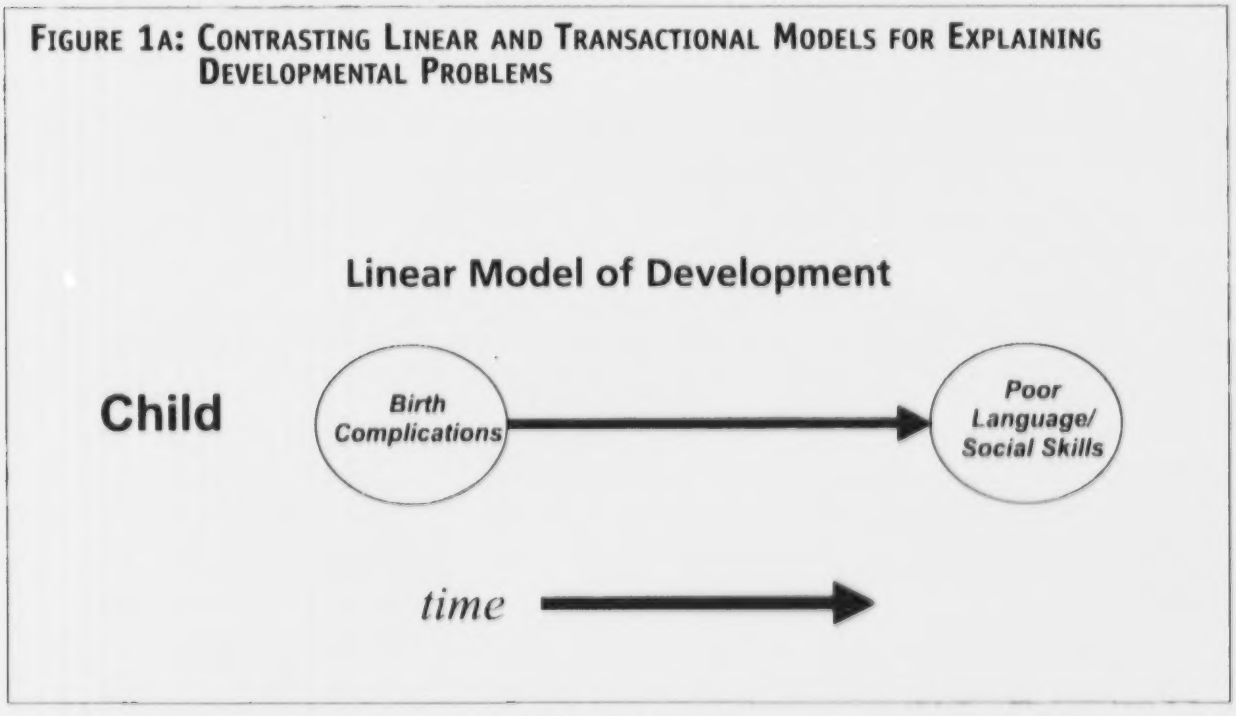
The Transactional Model of Development

The theoretical solution that Sameroff and Chandler (1975) proposed to the nature–nurture problem ran counter to the then-dominant (and now resurgent) idea that one could separate nature from nurture and calculate the percentage that each contributed to a person's functioning. The birth of an infant is seen as a biological separation that appears to produce an independent individual who will mature into an adult. This physical independence from other family members gives rise to the idea that psychological independence exists as well. Whether a child ends up with good or poor mental health, the thinking goes, depends on seeds that were already there at birth. As with most abstractions, scientists can calculate for a population on average how much of a specific behavior can be attributed to genes and how much to environment, but the reality of these calculations becomes suspect when they differ for different populations, and especially for different social classes within a population. What group averages conceal is that for an individual there is no separation between nature and nurture: They are inextricably intertwined. Although one can determine the genotype of each individual and the child-rearing beliefs and skills of the parents, these are potentials rather than actualities. On the nature side, biologists have discovered that the same genes are expressed differently in each cell as a function of their environment. On the nurture side, psychologists have discovered that the same parents respond differently to each of their children as a function of their individuality.

In the transactional model, how a child turns out is neither a function of the infant alone nor of experience alone, but a product of the combination of an individual and his or her experience. The transactional model embeds the child in an environment of social relationships that will amplify some early characteristics and minimize others. Whatever characteristics the infant may have been born with, in different families and with different sets of experiences the infant would have developed differently. The transactional model views the development of the child as a product of the continuous dynamic interactions between the child and the experience provided by his or her family and social context. The model places an equal emphasis on the effects of the child and of the environment. The experiences provided by the environment are not viewed as independent of the child. The child may have been a strong determinant of current experiences, but developmental outcomes cannot be systematically described without an analysis of the effects of the environment on the child.

This is not to say that some children with birth complications, especially severe anomalies, will not end up with developmental disabilities—but so will some children without birth complications. The research that Sameroff and Chandler (1975) reviewed seemed to support the idea that children with high-risk births ended up with later developmental problems not because of damage to the brain at birth but because of the negative effect such children had

FIGURE 1A: CONTRASTING LINEAR AND TRANSACTIONAL MODELS FOR EXPLAINING DEVELOPMENTAL PROBLEMS



on their caregivers. Figures 1a and 1b illustrate competing explanations for developmental problems. Figure 1a shows a linear biological explanation, and Figure 1b depicts the alternative transactional process.

Consider a generally calm mother who has been made somewhat anxious by a complicated childbirth. Her anxiety during the first months of her baby's life influences her into being uncertain and less appropriate in her interactions with the child. In response to such inconsistency, the infant may develop some irregularities in feeding and sleeping patterns that give the appearance of a difficult temperament. This difficult temperament decreases parenting pleasure, so the mother spends less time with her child. If she or other caregivers are not actively interacting with the child, and especially are not talking to the infant, the child may score poorly on later preschool language tests and be less socially mature.

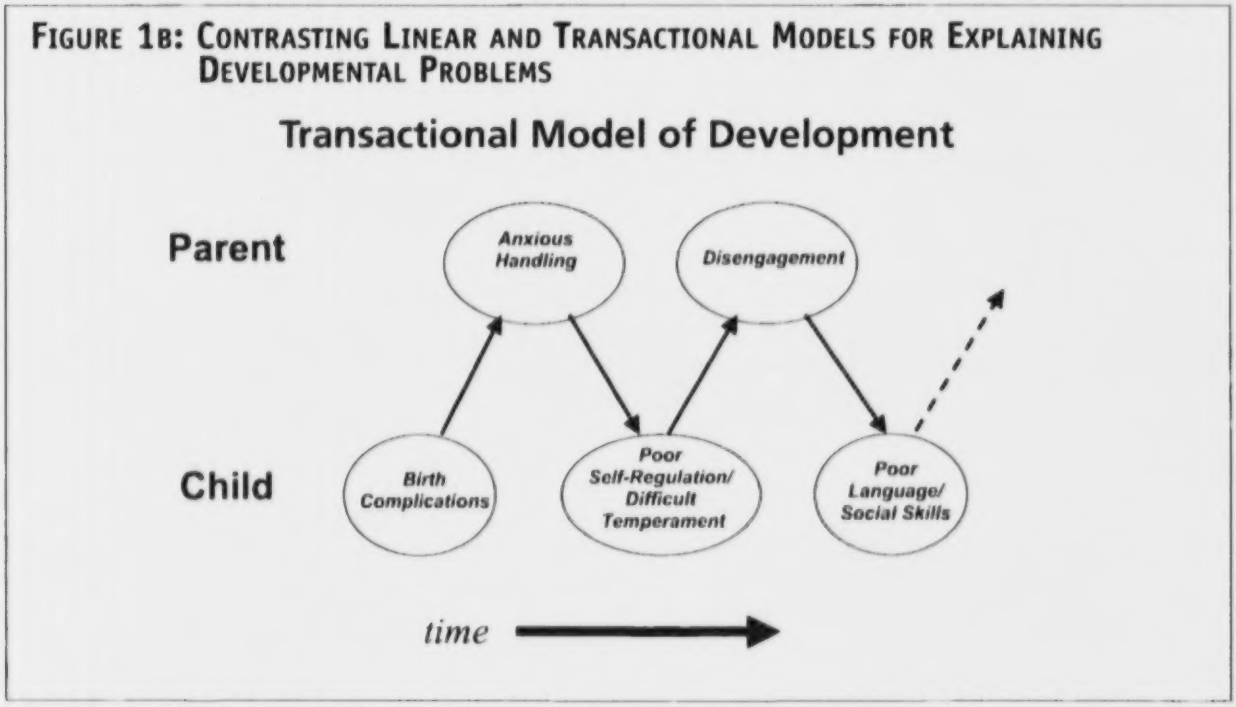
What was the "cause" of the poor outcome in this example? Was the poor verbal performance caused by the complicated childbirth, the mother's anxiety, the child's difficult temperament, or the mother's avoidance of verbal and social interaction? If one were to design an intervention program for this family, where would it be directed—at the child, the parent, or the relationship? The most proximal cause is the mother's avoidance of the child, yet one can see that such a view would oversimplify a complex developmental sequence. Would treatment be directed at eliminating the child's difficult temperament? At changing the mother's reaction? Or at providing alternative sources of verbal stimulation for the child? Each of these options would eliminate a potential dysfunction at some point in the developmental system.

This example demonstrates how developmental achievements are rarely consequences of child or parent characteristics alone. Not only is the causal chain between perinatal problems and early childhood problems extended over time, but it is also embedded in an interpretive framework. The mother's anxiety is based on an interpretation of the meaning of a complicated childbirth, and her avoidance is based on an interpretation of the meaning of the child's irregular feeding and sleeping patterns. Because transactions are located in the way the parent and child think about each other, we must comprehend their interpretive frameworks to predict or intervene effectively. Understanding how infants and their parents influence each other over time is a necessary prologue to recommendations for appropriate treatment. Once we have an overview of the complexity of the systems involved, we can turn to the search for nodal points at which to direct our interventions.

Testing the Transactional Model

The descriptive aspect of the transactional model emerged from the pioneering temperament research of Thomas, Chess, Birch, Hertzig, and Korn (1963) and Bell's (1968) reinterpretation of direction of effects research. Both efforts were designed to counter what Chess (1964) labeled the "mal de mere" orientations of psychoanalytic and behavioral theories that bad mothering caused bad children. Bell showed that many parent behaviors were not designed to socialize the child but, rather, were responses to the child's characteristics and behavior. Thomas, Chess, and Birch (1968) elucidated a clear transactional developmental path for a subset of children with

FIGURE 1B: CONTRASTING LINEAR AND TRANSACTIONAL MODELS FOR EXPLAINING DEVELOPMENTAL PROBLEMS



difficult temperaments. These children stimulated maladaptive parenting, which led to the children's later behavioral disturbance (see Figure 1b). When parents were not negatively reactive to their children's temperaments, no such pathway to behavioral deviance was found.

Building on these descriptive studies of parent–child relationships, Sameroff and Chandler (1975) proposed that transactional processes were a central part of development. They viewed children as engaged in active organization and reorganization. What was constant in a child's development was not a set of "traits," but the processes by which traits were maintained through the relationship between a child and his or her experience in a variety of social settings.

What is constant in a child's development is not a set of "traits," but the processes by which traits are maintained through the relationship between a child and his or her experience.

Twenty-Five Years of the Transactional Model

During the more than quarter-century since Sameroff and Chandler (1975) first articulated the transactional model, it has been referenced extensively in the developmental literature. All too often, however, it is used to emphasize the unidirectional effects of environmental risk factors on development, rather than the more complex bidirectional interplay between dynamic systems. Despite these issues, a growing body of research in several developmental domains has set about testing transactional models and disentangling complex bidirectional processes.

Evidence of transactional processes can be found at all points in development. Some of the earliest processes involve the establishment of the unique infant–caregiver attachment relationship. Attachment theorists (Sroufe, Carlson, Levy, & Egeland, 1999) have argued that the quality of this relationship has great implications for subsequent events, while at the same time being intimately tied to events of the past. A central tenet of attachment theory is that an infant's secure relationship with the primary caregiver sets the stage for healthy emotional development and subsequent relationships outside of the family context (Bowlby, 1969; Bretherton, 1990). The transactional linkages in attachment theory begin with caregiver behavior that establishes the quality of the attachment representation, which in turn affects the quality of the child's later social interactions.

In an investigation of the development of secure infant–mother attachment relationships over the first year of life, Crockenberg (1981) found that irritable infants were more likely to develop insecure attachment relationships as a result of the unresponsive mothering that is characteristic of contexts that offer limited social support. Crockenberg concluded that these findings are best understood from a transactional perspective because of the role played by the child in eliciting parent interactions.

A compelling example of the effect of maternal beliefs and preferences on later child functioning comes from a study of mothers who preferred one of their twins, a phenomenon that can occur as early as 2 weeks after birth (Minde, Corter, Goldberg, & Jeffers, 1990). These preferences tended to be stable, lasting for at least the 4 years that the families were followed in the study. The particular aspect of the child that triggered the transaction varied, with some mothers preferring temperamentally easier and healthier children, and others preferring the more "strong-willed" or sickly of the twin pair. Whatever the child characteristic that triggered maternal preference, the preferred twins had higher scores on the Bayley at 12 months of age, higher scores on the Stanford-Binet at age 4 years, and fewer behavior problems than their twins. This study highlighted the transactional nature of socialization processes through an examination of the extent to which mothers' attributions about their infants led to differential responsiveness, which then served to affect later child outcomes in ways that confirmed and solidified the mothers' initial preferences.

Gerald Patterson and his colleagues (1982, 1986) have vividly described aggressive behavior in children as an example of transactional processes in the development of mental health problems. Patterson (1982) hypothesized that antisocial behavior has its roots in family interactions and the cycle of behavioral responses of one family member to another over time. Patterson found "cycles of coercion," in which inept parenting produces an antisocial child who is rejected by healthy peers, struggles academically, and is left with low self-esteem. What may start as developmentally appropriate noncompliance on the part of a toddler in such a family escalates to physical aggression. Patterson and his colleagues found that coercive cycles were more likely to begin in families characterized by unskilled parents, a child with a difficult temperament, and additional social and economic stressors. The escalating transactional nature of this positive feedback loop is best illustrated by Patterson's (1986) own words: "What leads to things getting out of hand may be a relatively simple affair, whereas the process itself, once initiated, may be the stuff of which novels are made" (p. 442).

There is a difference between descriptive developmental studies, in which the evidence is based on correlations between influences and outcomes, and experimental studies, in which children or parents are randomly assigned to groups that receive different experiences. Using an elegant design, Bugental and her colleagues (Bugental, Caporael, & Shennum, 1980) explored the association between child responsiveness and controllability and adult attribution and interaction styles. The researchers trained 7- to 9-year-old boys to act as "confederates" who would interact with

parents who had either high or low levels of an internal sense of power. The children were trained to be either responsive or unresponsive during a toy construction task. Unresponsive child confederates affected the behavior only of adults who saw themselves as having limited control over their lives. When confronted with unresponsive children, these low-power adults were less assertive than adults with feelings of greater control. When matched with responsive children, both groups of adults behaved the same. Bugental and Shennum (1984) concluded that adults bring with them to the parenting role a set of beliefs about relationships with children, based on their history of social experiences, that influences their interpretations of the child's behavior, their subsequent behavioral responses, and—in a transactional fashion—the later behavior of the child.

Another innovative experimental approach to studying transactions focused on parental interactions with preterm babies. Despite evidence that early differences between premature and full-term infants decline over time, some mothers to continue to interact differently with their premature infants (Barnard, Bee, & Hammond, 1984). Stern and Hildebrandt (1984) showed adults video footage of an infant who was labeled as either being full-term or premature. They found that infants who were labeled as premature were rated more negatively by college students and mothers than infants labeled as full-term. They went on to determine whether these adult stereotypes and attitudes toward premature children would affect their behavior during interactions. The researchers introduced adults to an actual, unfamiliar infant, randomly labeled either full-term or premature (Stern & Hildebrandt, 1986). Again, the prematurity label was found to trigger stereotypical beliefs: infants labeled premature were rated as smaller, less cute, finer-featured, and less likable than infants labeled full-term. Moreover, these mislabeled infants were touched less and given more babyish toys to play with. These effects on adult attitudes were carried back to the child in a transaction in which infants labeled as premature exhibited less positive emotion in their interactions with the misinformed adults (Stern, Karraker, Sopko, & Norman, 2000).

Transactional Interventions

Although experimental data augment what we can learn from descriptive studies of the development of different groups of infants or parents, we can never fully test causal hypotheses for most groups of interest because we cannot randomly assign infants to have different temperaments or parents to be randomly competent or inept. However, the converging evidence for the existence of bidirectional, reciprocal relationships between infants and their caregivers provides a strong basis for intervening more effectively to improve the lives of families facing challenges from either child or parent.

Sameroff and Chandler (1975) highlighted the important influence of socioeconomic status on the outcome of children at risk for developmental disabilities. However, interventions to change the primary determinants of social class—that is, the parents' educational, occupational, and financial attainment—are beyond the scope of infant development specialists. It will take major changes in the political and economic climate of the nation to alter families' highly stable socioeconomic risk status significantly for the better (Sameroff, Seifer, Baldwin, & Baldwin, 1993). For the most part, then, infant development specialists direct early interventions at the here-and-now interactions of children and their caregivers. Sameroff and Chandler's theoretical contribution, the transactional model, is useful in the treatment of early relationship problems, particularly for identifying targets and strategies of intervention.

The principle that continuity in an individual's behavior is a reflection of the family system provides a rationale for expanding the focus of intervention efforts on behalf of an infant or young child. By examining the strengths and weaknesses of the many dimensions of the family child-rearing system, the clinician can identify categories of targets that define and contain the scope of the intervention while maximizing cost efficiency.

In a transactional system, the subsequent behavior and competence of the child is seen as function of how the parent reacts, not as an intrinsic characteristic of the child. One often sees a three-part sequence in which, first, infants stimulate their parents, either through their appearance or behavior; second, the parents impose some meaning system on the input; and third, the parents then react with some form of caregiving (see Figure 2). Where relationships are problematic, interventions should be directed at one or more of these three parts. In some cases, small alterations in child behavior may be all that is necessary to reestablish a well-regulated parent–child relationship. In other cases, changes in the parent's representation of the child may be the most strategic intervention. In a third category are cases that require improvements in the parents' ability to take care of the child. These intervention categories have been labeled the "three R's" of intervention— remediation, redefinition, and reeducation (Sameroff, 1987; Sameroff & Fiese, 2000).

A conceptual model for the identification of family problems would lead not only to better program design but to better evaluation models and research designs as well. An array of therapies has been developed to intervene with early relationship problems that can target the different parts of the transactional system (Sameroff, McDonough, & Rosenblum, in press). A decision tree can be described for choosing the appropriate form of transactional early intervention (Sameroff & Fiese, 1990, 2000).

The clinician must first decide whether remediation is appropriate or viable. In the case of remediation, the child is defined as developmentally atypical. The focus of remediation is to change the child—for example, through supplemental feeding for malnourished infants or medication of hyperactive school children. Most families with such a child are thought to need intervention, but little effort is made to change the

parents. There are at least two instances in which remediation of the child cannot be achieved: when there is no procedure available to modify the condition of the child—for example, with tiny, low-birthweight infants—or when nothing can be found in the child that needs changing. In such cases, the clinician focuses on the parents' responses to the child's situation.

Redefinition interventions are prescribed when the parents' representation of the child inhibits their ability to respond to the child with appropriate caregiving. In this situation, the maladapted relationship between parents and their infant requires changes in the parents' attitudes and beliefs. The treatment may simply involve augmenting the parents' ability to see the normal in the abnormal—for example, to recognize that preterm babies, although different in size, have cognitive and social–emotional needs and patterns of development similar to full-term babies. In a more complex situation, psychotherapy can help parents to examine their feelings about themselves in the role of a mother or father.

In a transactional framework, remediation, redefinition, and reeducation are the "three R's" of intervention.

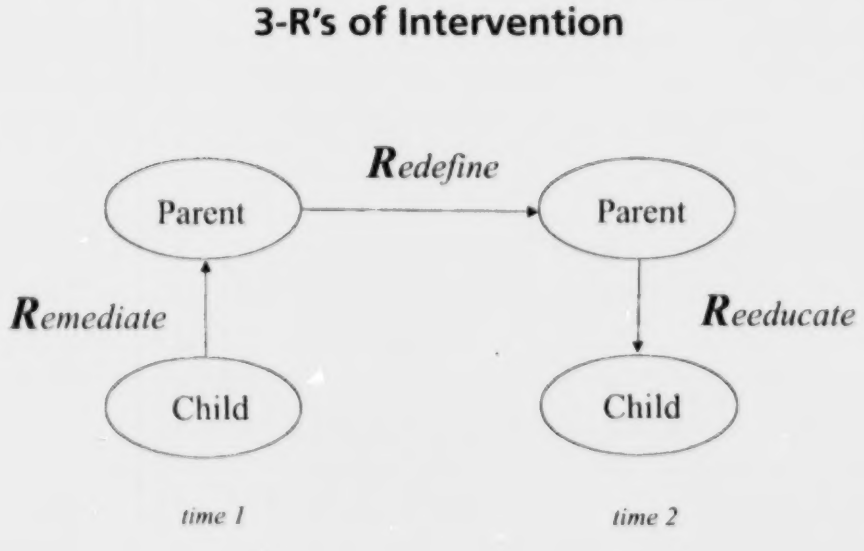
The third "R," reeducation, is prescribed when the parent has a healthy acceptance of the child but lacks certain caregiving skills or knowledge. This is frequently the case with teenage mothers. Reeducation is designed to improve parents' ability to interact with the infant, especially where adaptations to ordinary caregiving must be made, as in the case of handling very low-birthweight infants or properly positioning babies with motor impairments.

How Have Things Changed?

The transactional model was originally described to emphasize the dynamic relation between child and context across time, with particular relevance to developmental outcomes in children with perinatal complications (Sameroff & Chandler, 1975). The transactional view has become central to current models of regulation and self-regulation that are permeating the developmental literature (cf. Boekaerts, Pintrich, & Zeidner, 2000; Bradley, 2000). We now view the individual as having a major role in modifying social experience through both eliciting and selecting processes; we also see the individual as having a major role in modifying biological experience, through both stress reactions and medication (Cicchetti & Tucker, 1994). These regulations provide clear evidence for the biopsychosocial unity of human functioning.

Contemporary reconceptualizations of temperament have been part of these advances. Instead of conceptualizing temperament as a set of traits inherent in the child, developmentalists now think of temperament as a set of individual differences in the way children regulate experience (Rothbart & Bates, 1998). This view makes temperament a relational construct rather than a personal one. Another area that illustrates the child's contribution to transactional pathways involves the maltreatment of children living under the care and supervision of the child welfare system.

FIGURE 2: THE 3-R'S OF EARLY INTERVENTION WITHIN A TRANSACTIONAL MODEL



In theory, on removal from an abusive situation, children should go on to more positive outcomes. Unfortunately, this does not seem to be universally true. Some children who have been abused in their families are maltreated by later caretakers, including foster parents (Milowe, Lourie, & Parrott, 1964). Something in these children seems to be carried forward into new relationships. The changes wrought in these children by their experience of maltreatment persist over time, influencing their future relationships.

Although Sameroff and Chandler (1975) described dynamic reciprocal interchanges as important features of their transactional model, for most of their readers the take-away message was that low socioeconomic status presented many risks for developmental problems (Sameroff, Bartko, Baldwin, Baldwin, & Seifer, 1998). For this audience, the paper broadened what had been an exclusive focus on the child's characteristics as the explanation of developmental outcomes to include the social context as well. The negative effects of poverty on children (McLoyd, 1998), including children with perinatal complications (Infant Health and Development Program, 1990), have been increasingly well documented, but an exclusive focus on risk factors misses the important fact that they are probabilities, not certainties. Among any group of children who face a given social or, for that matter, biological risk factor, there will be some who develop quite normally. Frequently it is the majority who do so. Studies of resilience are a growth industry (cf. Luthar, 2003), reporting on children who have overcome poverty, or parental mental illness, or maltreatment. What these studies increasingly find is that the life course of any particular child includes many influences that have the power to change things for better or worse.

Children affect their environments and environments affect children. Children are neither doomed nor protected by their characteristics or by the characteristics of their caregivers alone.

For clinical purposes it remains important to recognize continuities in the characteristics of the child, in the child's ecological and socioeconomic circumstances, and in the dyadic interactions between the child and parenting figures. Each of these continuities is more or less open to change. Given these continuities, the clinician uses transactional analysis to discover the conditions under which positive discontinuities could occur—where a change in one partner has the opportunity to reorganize the behavior in the other, or a change in one setting would reorganize another setting. Such analyses identify opportunities and also set limits for intervention efforts to improve developmental success.

Under real-life circumstances, the best we can do is to describe family systems. Attributing causation to any element of the system always brings up the question of the history of that element. Is difficult temperament during infancy an expression of biological tendencies or the result of prior parenting? Is inept caregiving an expression of parent inadequacy or a reaction to prior experience with the child? As the child grows, these influences become more and more difficult to untangle—the direction of effects dilemma. Sameroff and Peck (2001) were surprised to find that adolescents whose parents made more efforts to prevent behavioral and educational problems in their youth had worse outcomes. Their interpretation was that by adolescence, parents only engaged in these efforts if their children still had problems. For the children who were doing well, the parents were less concerned.

We have focused this article on transactions between parents and children, but we recognize that children and their parents are involved in many ecological settings that are also changing and being changed by their participants. Explaining developmental outcomes will require attention to these multiple sources of influence as well as to the parent–child dyad. This issue is clearest in intervention studies in which the interveners are part of the system, but it is equally true of all studies beyond infancy where the parent–child relationship begins to pale in the face of peer and school involvements that occupy more of the youth's time.

As far as the transactional model is concerned, several things are clear: Children affect their environments and environments affect children. In addition, environmental settings affect and are affected by each other. Moreover, these effects change over time in response to normative and nonnormative events. Children are neither doomed nor protected by their own characteristics or by the characteristics of their caregivers alone. The complexity of the transactional system opens up the possibility for many avenues of intervention to facilitate the healthy development of infants and their families.

REFERENCES

Barnard, K. E., Bee, H. L., & Hammond, M. A. (1984). Developmental changes in maternal interactions with term and preterm infants. *Infant Behavior and Development, 7*, 101–113.

Bell, R. Q. (1968). A reinterpretation of the direction of effects in studies of socialization. *Psychological Review, 75*, 81–95.

Boekaerts, M., Pintrich, P. R., & Zeidner, M. (Eds.). (2000). *Handbook of self-regulation*. San Diego, CA: Academic Press.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bradley, S. J. (2000). *Affect regulation and the development of psychopathology*. New York: Guilford Press.

Bretherton, I. (1990). Open communication and internal working models: Their role in the development of attachment relationships. In R. Thompson (Ed.), *Nebraska Symposium on Motivation: Vol. 36. Socioemotional development* (pp. 59–113). Lincoln: University of Nebraska Press.

Bugental, D. B., Caporael, L., & Shennum, W. A. (1980). Experimentally produced child uncontrollability: Effects on the potency of adult communication patterns. *Child Development, 51*, 520–528.

Bugental, D. B., & Shennum, W. A. (1984). "Difficult" children as elicitors and targets of adult communication patterns: An attributional-behavioral transactional analysis. *Monographs of the Society for Research in Child Development, 49*.

Chess, S. (1964). Mal de mere. *American Journal of Orthopsychiatry, 34,* 613–614.
Cicchetti, D., & Tucker, D. (1994). Development and self-regulatory structures of the mind. *Development & Psychopathology, 6,* 533–549.
Crockenberg, S. B. (1981). Infant irritability, mother responsiveness, and social support influences on the security of infant-mother attachment. *Child Development, 52,* 857–865.
Dixon, W. E. (2002). *Twenty studies that revolutionized child psychology.* Upper Saddle River, NJ: Prentice Hall.
Fawer, C. L., Besnier, S., Forcada, M., Buclin, T., & Calame, A. (1995). Influence of perinatal, developmental and environmental factors on cognitive abilities of preterm children without major impairments at 5 years. *Early Human Development, 43,* 151–164.
Infant Health and Development Program. (1990). Enhancing the outcomes of low-birth-weight, premature infants. *Journal of the American Medical Association, 263,* 3035–3042.
Luthar, S. S. (Ed.) (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Cambridge University Press.
McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *American Psychologist, 53,* 185–204.
Milowe, I. D., Lourie, R. S., & Parrott, R. H. (1964). Child's role in battered child syndrome. *Journal of Pediatrics, 65,* 1079–1081.
Minde, K., Cotter, C., Goldberg, S., & Jeffers, D. (1990). Maternal preference between premature twins up to age four. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 367–374.
Pasamanick, B., & Knobloch, H. (1961). Epidemiologic studies on the complications of pregnancy and the birth process. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 77–94). New York: Basic Books.
Patterson, G. R. (1982). *Coercive family interactions.* Eugene, OR: Castalia Press.
Patterson, G. R. (1986). Performance models for antisocial boys. *American Psychologist, 41,* 432–444.
Rothbart, M., & Bates, J. E. (1998). Temperament. In W. Damon (Ed.), *Handbook of child psychology* (5th ed., Vol. 3, pp. 105–176). New York: Wiley.
Sameroff, A. J. (1987). The social context of development. In N. Eisenberg (Ed.), *Contemporary topics in developmental psychology* (pp. 273–291). New York: Wiley.
Sameroff, A. J., Bartko, W. T., Baldwin, A., Baldwin, C., & Seifer, R. (1998). Family and social influences on the development of child competence. In M. Lewis & C. Feiring (Eds.), *Families, risk, and competence* (pp. 161–186). Mahwah, NJ: Lawrence Erlbaum Associates.
Sameroff, A. J., & Chandler, M. J. (1975). Reproductive risk and the continuum of caretaking casualty. In F. D. Horowitz, M. Hetherington, S. Scarr-Salapatek, and G. Siegal (Eds.), *Review of child development research* (Vol. 4, pp. 187–244). Chicago: University of Chicago Press.
Sameroff, A. J., & Fiese, B. H. (1990). Transactional regulation and early intervention. In S. J. Meisels (Ed.), *Handbook of early childhood intervention* (pp. 119–149). New York: Cambridge University Press.
Sameroff, A. J., & Fiese, B. H. (2000). Models of development and developmental risk. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 3–19). New York: Guilford Press.
Sameroff, A. J., McDonough, S. C., & Rosenblum, K. L. (in press). *Treating early relationship problems: Infant, parent, and interaction therapies.* New York: Guilford.
Sameroff, A. J., & Peck, S. (2001). *Individual and contextual influence on adolescent competence.* Symposium presentation at the Biennial meetings of the Society for Research in Child Development, Minneapolis, MN.
Sameroff, A. J., Seifer, R., Baldwin, A., & Baldwin, C. (1993). Stability of intelligence from preschool to adolescence: The influence of social and family risk factors. *Child Development, 64,* 80–97.
Sroufe, L. A., Carlson, E. A., Levy, A. K., & Egeland, B. (1999). Implications of attachment theory for developmental psychopathology. *Development and Psychopathology, 11,* 1–13.
Stern, M., & Hildebrandt, K. (1984). A prematurity stereotype: The effects of labeling on adults' perceptions of infants. *Developmental Psychology, 20,* 360–362.
Stern, M., & Hildebrandt, K. A. (1986). Prematurity stereotyping: Effects on mother–infant interaction. *Child Development, 57,* 308–315.
Stern, M., Karraker, K. H., Sopko, A. M., & Norman, S. (2000). The prematurity stereotype revisited: Impact on mothers' interactions with premature and full-term infants. *Infant Mental Health Journal, 21,* 495–509.
Thomas, A., Chess, S., & Birch, H. G. (1968). *Temperament and behavior disorders in children.* New York: New York University Press.
Thomas, A., Chess, S., Birch, H. G., Hertzig, M. E., & Korn, S. (1963). *Behavioral individuality in early childhood.* New York: New York University Press.
Werner, E. E., Bierman, J. M., & French, F. E. (1971). *The children of Kauai: A longitudinal study from the prenatal period to age ten.* Honolulu: University of Hawaii Press.
Werner, E. E., & Smith, R. S. (2001). *Journeys from childhood to mid-life: Risk, resilience, and recovery.* Ithaca, NY: Cornell University Press.
Wilson, R. S. (1985). Risk and resilience in early mental development. *Developmental Psychology, 21,* 795–805.

Thirty Years in Infant Mental Health

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In 1967, I started medical school at the University of Colorado, anticipating a career in family medicine or pediatrics. Little did I know what was in store for me. Through a combination of serendipity, historical accident, a network of teachers and mentors, and opportunities to do work I love, I have been able to spend 30 years in the field of infant mental health—almost as long as the field has existed. But unlike Ron Lally, Stanley Greenspan, Berry Brazelton, Selma Fraiberg, and others who were already leaders in their fields in the mid-1970s, when they founded ZERO TO THREE, I was just beginning my career in psychiatry at that time, as a research fellow. I hope that young professionals who are interested in infant mental health can see something of themselves in the stories of how I grew in a growing field and that my contemporaries will recognize how we can help a new generation train for demanding but productive work in infant mental health.

at a glance

- In the late 1960s and early 1970s, psychiatrists, psychoanalysts, and developmental psychologists pioneered the study of infant mental health.
- A systems approach to infant mental health includes attention to basic family needs.
- *DC:0-3* has helped fill the need for developmentally sensitive diagnostic system that can serve as a "common language" for clinicians, researchers, and families.
- Infant mental health knowledge now informs practice in NICUs, Early Head Start, services for young children who have been abused or neglected, and programs for mothers in recovery from substance abuse and their children.

In the Beginning

Not long after I arrived at medical school, one of my classmates told me that to get a summer research fellowship beginning in June, I had to apply in October. I headed for the notebooks where proposals were filed. One fellowship plan, entitled "Infant Emotional Expressions," involved studying infant state organization and sleep patterns with Robert Emde (Emde, Gaensbauer, & Harmon, 1976). Bob and I met in early September 1967. Three dozen years later, we're still at the University of Colorado together (and at ZERO TO THREE—but that's getting ahead of the story). In addition to Bob Emde, many members of the faculty in child development at Denver University, including René Spitz and Lou Sander, mentored me while I was in medical school. Most of these experiences helped me to understand "normal" developmental processes in children and adults.

To develop an alliance with the staff, I had to figure out how to be genuinely helpful to them. It took almost a year before a sense of trust developed between us.

I spent my early years with Bob Emde studying infant facial expressions, describing the onset of the social smile, detailing stranger distress, and outlining sleep stages in infants (Emde & Harmon, 1972; Emde, Harmon, Metcalf, Koenig, & Wagonfeld, 1971; Emde, McCartney, & Harmon, 1971; Harmon & Emde, 1972). During that time, René Spitz returned from Europe and influenced many of our research activities. A towering figure in psychoanalysis, infant observation, and the study of child deprivation, he was also a source of many stories about Vienna in the early days of psychoanalysis, details about the infants described in "Hospitalism" (Spitz, 1945) and "Anaclitic Depression" (Spitz, 1946), and was someone who enjoyed spending time with his students. I reviewed most of his films (the Spitz Archives were for many years in our department under Bob Emde's directorship) with him and learned a great deal about observation, substandard and pathological maternal care, and much about René himself.

To Washington

After I completed my training in general psychiatry, I probably would have been sent to Vietnam had I not been fortunate enough to receive a research fellowship in child development at the National Institute of Child Health and Human Development (NICHD) with psychologist Leon Yarrow (Yarrow & Harmon, 1975). Not only did Leon teach me a great deal more about research and child development, but he also pointed me toward Reginald Lourie, the "father" of ZERO TO THREE.

When I told Leon that I hoped to do some clinical work during my research fellowship, he suggested that I should try to arrange part-time training in child psychiatry with Reginald Lourie. Reg was kind enough to meet with me in October 1973, but he told me both on the phone and in person that he had just retired from Hillcrest Children's Center and as head of Child Psychiatry at Children's Hospital and so didn't have the time or the influence to work out training for me. I must have looked seriously disappointed (devastated and angry would probably be more accurate descriptors of my emotional state), so Reg humored me by asking a few personal questions. I mentioned my relationship with René Spitz. This made Reg pause. He looked into a box beside his desk and pulled out a card. He looked at me and smiled, then read "Dearest Reg: Merry Christmas and Happy New Year. My time in Colorado continues to go well. I have so many wonderful students, most under the direction of Dr. Robert Emde. One of them will be coming to Bethesda, and I suggested he contact you. He is very interested in clinical work with young children...." Reg asked, "Does 8 a.m. Monday work for supervision with me? Let me take you across the street to the Mary McLeod Bethune Infant Education Center. You're now their psychiatric consultant."

At Bethune

So began 3 years of work, supervised by Reg, at a new infant education and child-care center in the heart of Washington, DC's, "riot corridor"—the section of the city largely destroyed in the upheavals that followed the assassination of Martin Luther King, Jr. in 1968. I was the only non-African American working at Bethune. I learned patience there and refined my observational skills. I learned that to develop an alliance with the staff, I had to figure out how to be genuinely helpful to them. It took almost a year before a sense of trust developed between us.

Although I was always, and continue to be, interested in basic child development issues, I was also committed to applying what we know about normal development to "at-risk" and "clinically disordered" children. Observing the babies and toddlers at Bethune, I noted that many of them seemed to be losing language milestones at around ages 16–18 months. I also noted the children had a lot of colds and flu-like symptoms. It dawned on me that maybe some of them had ear infections. So, I began to arrive at the center with my "doctor's kit," doing screening ear exams on the children who were sick. Sure enough, many had infections. I initially referred them to a nearby health center, but later Bethune staff asked me to administer treatment.

Not long afterward I found myself setting up a screening program for children at risk for lead poisoning. As part of Bethune's efforts to provide job training and improve the community generally, staff and community residents were going from house to house, stripping off lead paint and repainting the inside (and outside) of many homes and apartments. I had another idea about the children's developmental problems—what about lead poisoning? I set up a screening program for children who the staff told me were at

high risk and had symptoms that might be associated with lead toxicity. Again (much to my surprise, as lead poisoning was rare in Colorado), I found several children who needed treatment.

My work with one family in particular cemented my alliance with the Bethune Center. Mrs. K. was "difficult" and not cooperating with the conditions of her job training. When I met her, I realized that she had a thought disorder with paranoia. She eventually told me that she had been diagnosed with schizophrenia as a teenager and had stopped taking her medications. We also had concerns about Cassie, Mrs. K.'s 2-year-old daughter. Some staff members wondered if she might be showing signs of an early psychotic disorder. I focused on helping Cassie first and on the mother–child relationship. As my alliance with Mrs. K. improved, she relented and allowed me to treat her with appropriate medication.

It turned out that Cassie had lead toxicity so severe that she needed inpatient care. (Because of her paranoia, Mrs. K. had not allowed the Bethune team to strip lead paint from her apartment.) The Hospital for Sick Children suggested I admit Cassie and serve as her attending physician, so I learned more about lead toxicity and its treatment than most psychiatrists. Fortunately, Mrs. K. was now cooperating with the center and its job training staff, allowed the paint team to remove the lead paint from her home, and was willing to begin to work on her parenting skills.

At Bethune, I learned to take a systems approach to infant mental health—to be prepared to meet the basic needs of a family as well as their mental health needs.

The Founding of a Field

When I first arrived at the Social and Behavioral Sciences Lab, Leon suggested I read a prepublication manuscript by Mary S. Ainsworth (1973). This article discussed a new topic to me, "attachment," as described by John Bowlby (1969) and elaborated by Ainsworth and her research. I was knowledgeable in psychoanalytic theories of early relationship development and obviously influenced by Spitz's (1959) Genetic Field Theory, but this article proposed a different view of development. Luckily, our lab was collaborating with the Ainsworth team and using the strange situation paradigm in some of our studies of attachment and mastery motivation. At the time, I didn't realize how broadly Ainsworth's work would influence developmental psychology and psychiatry, although I could imagine clinical applications. During my time at NICHD we used data from the attachment assessment, measures of stranger distress, and mastery motivation to better understand the relationship between social–emotional development and mastery behavior (Harmon, Morgan, & Klein, 1977; Harmon, Suwalsky, & Klein, 1979; Jennings, Harmon, Morman, Gaiter, & Yarrow, 1979).

During the second year of my NICHD training, Leon mentioned that Reg Lourie was organizing a little "study group" of researchers and clinicians interested in "infant mental health." He was allowed to bring one "student" to these meetings and asked me to attend. Other members of the study group included Stan Greenspan, Serena Wieder, Sally Provence, Al Solnit, Berry Brazelton, Ron Lally, and Selma Fraiberg. As time went on, additional members joined the group, which went on to found ZERO TO THREE (see Greenspan & Wieder, pp. 6–13; and Lally, pp. 29–34, this issue). It was a very exciting time and a real privilege to watch the founding of the field. One of the " goals of the original group was to develop mechanisms to train interested professionals in infant mental health. Twenty-five years later, ZERO TO THREE is pursuing this goal in many ways—through training programs that are part of the Harris Professional Development Network, the Early Head Start National Resource Center, the Leadership Development Initiative, training in diagnostic classification, the National Training Institute, program consultation in reflective practice, and other initiatives.

In 1976, after I had returned to Colorado, the study group invited me to present my research on attachment in premature infants (Gaensbauer, Mrazek, & Harmon, 1981; Gaensbauer & Harmon, 1982; Harmon, Morgan, & Glicken, 1984). I showed a videotape of a strange situation paradigm in which an abused infant clearly demonstrated her attachment to her foster mother, including weeping loudly when the foster mother left the room. Selma Fraiberg was so upset by the videotape that she stood up, pointed her finger angrily at me, and admonished me to stop further traumatizing infants who had a long history of separation from attachment figures by again separating them in an unfamiliar, frightening research laboratory. I almost quit the field on the spot. What I learned, however, is that as an advocate for structured assessment of infants and their parents and of using research methods to help us understand clinical problems, I needed to remember the medical mantra, "First, do no harm."

Selma remained upset about our work for some time. However, after several months of correspondence, I received an autographed copy of "Ghosts in the Nursery," (Fraiberg, 1975) with a note inside saying "To Bob, Pax and warmest wishes, Selma." Selma also offered me the job of medical director of the Infant–Parent Program in Ann Arbor, which I declined. Shortly thereafter, Selma, Jeree Pawl, and other members of the team moved to the University of California, San Francisco.

Several years later, back in Colorado, I was part of a MacArthur network on the transition from infancy to childhood, chaired by Bob Emde. Mary Ainsworth, Mary Main, Joan Stevenson-Hinde, John Bowlby, and others discussed practical implications of attachment theory. We argued a great deal, but our discussions helped me to think about clinical applications of attachment theory and research in a clinically useful way. John Bowlby, for example, observed that throughout life, important relationships can influence the internal working models of relationships that we carry with us from childhood. This insight points to the potential positive impact of psychotherapy and other relational experiences.

Clinical Practice at the University of Colorado School of Medicine

Having resumed training in child psychiatry after returning to Colorado, I was doing research but still trying to figure out a way to do clinical work related to infants and families. As part of my recruitment strategy for my research on low-birthweight, preterm infants, I was the "attending" psychiatrist in the neonatal intensive care unit (NICU). My activities consisted of a holding a weekly conference with staff about psychosocial issues concerning the babies and their families, counseling distressed parents, and trying to make the NICU environment more sensitive to the developmental needs of families and infants.

For much of my life, I've found my own personal experience to be an important guide to my clinical work and research questions.

One of the things I quickly learned was that infants die and, at that time, no one seemed to know what to do to help families who experienced a fetal loss. For much of my life, I've found my own personal experience to be an important guide to my clinical work and research questions. Unfortunately, my wife and I had experienced three second-trimester pregnancy losses while I was beginning my work in the NICU. I was very familiar with the pain, grief, and sense of loss this engendered. What to do? I found others in the NICU and at UCSM interested in this issue. Together, we developed a clinical research program on the impact of perinatal loss on parents. We also developed intervention programs, such as the Neonatal Hospice Program at Children's Hospital (Harmon, Glicken, & Siegel, 1984) and the Fetal Demise Program at University Hospital (Davis, Stewart, & Harmon, 1989). Our goal was to document that perinatal loss was similar to other losses and to provide sensitive, family-centered services to parents whose baby had died. We offered pictures, locks of hair, and footprints to help them remember their baby. We also began a yearly memorial service, coordinated by the hospital chaplain, to help families remember their children.

Some families needed more intensive help, however. We realized that we had raised NICU staff awareness about the impact of perinatal loss, but we lacked appropriate resources for treatment when indicated. We established the Infant Psychiatry Clinic (Harmon, Stall, Emde, Siegel, Kempe, Margolin, et al., 1990) as part of the Outpatient Clinic in Child and Adolescent Psychiatry at University Hospital, where child psychiatry residents were assigned infant cases as part of their regular clinical load. But how should we define "infant cases?" Given our work in the NICU and with fetal loss, we decided to use a definition of infant psychiatry that included the transition to parenthood, perinatal loss, and any type of behavioral or emotional problem in children younger than age 5 years. At first our definition of infant mental health attracted criticism, but today this broad developmental focus seems to be accepted.

In the Infant Psychiatry Clinic, faculty as well as residents worked directly with very young children. When I was director of the Pediatric Psychology and Psychiatry Liaison Service at University Hospital, a tragic family situation helped me appreciate the poorly recognized role that trauma plays in the lives of young children. I was called to see Sally, a 26-month-old girl, and Martha, her mother, both of whom had been stabbed by the father/husband. The man was a successful local attorney who had had a psychotic break, including delusions that his wife and children were "taking his power" from him. In a rage, he stabbed his wife, daughter, and 6-month-old son. The three barely survived.

I had no idea how to begin helping this family. But I went to see the little girl daily, and as she slowly recovered from her coma and her wounds, we began to develop a relationship. When Martha was finally discharged from intensive care, I arranged a visit between the two of them. Much to my surprise, Sally reacted with anger and fear at seeing her mother (some of her reaction was probably related to how bad her mother looked from having been choked). After mother and daughter went home, I began twice-weekly psychotherapy with Sally, weekly sessions with Martha, and regular dyadic therapy as well.

As Sally played out the events of "the incident" (as the family called it), it became clear that her play had become ritualized and was at odds with what had really occurred. In every play session, an alligator would sneak into the little girl's room and bite her, but it was a "mommy" alligator, not a "daddy" alligator. One day the play suddenly made sense to me: Sally was blaming her mother for not protecting her, and she had developed "post-traumatic play" about the event, which only increased her anxiety and anger at her mother. Slowly, I began to replay the alligator attack by changing the gender of the alligator. Now Sally was really mad at me, but after several sessions, she burst into tears and acknowledged that yes, she remembered now, it was her daddy who had hurt her.

So began 4 years of treating Sally and Martha. Issues we dealt with included visits with her father at the state hospital where he had been sent for treatment, reappearance of symptoms when an alligator escaped from the Denver zoo and began munching on birds and pets in the area, and acceptance of a stepfather and a new sibling into the family. This tragic situation offered a real opportunity to be helpful to the family and to learn about trauma in young children.

ZERO TO THREE and *DC: 0–3*

In 1986 I was invited to join the Board of Directors of ZERO TO THREE. That year, Kathryn Barnard, as chair of the Research Facilitation Committee, appointed a Diagnostic Classification Task Force, chaired by Stanley Greenspan and Serena Wieder, to explore the development of a diagnostic

system to classify mental health and developmental disorders in infants and young children. I joined the Task Force. The ZERO TO THREE Board was quite divided on the issue of diagnosis. Some members argued that diagnosis meant "labeling"—and thereby stigmatizing—young children. Others maintained that to provide mental health services to young children, we needed a system that was developmentally sensitive but that would also be useful to serve as a "common language" among clinicians for clinical case discussions, clinical research, and eventually reimbursement for services provided to families with young children. In 1994, the stimulating but often adversarial process resulted in a less-than-perfect but clinically useful document *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (*DC: 0–3*; ZERO TO THREE, 1994).

In 1990, I was asked to present the task force's thinking to date at the Infant Mental Health Conference in Texas. This turned out to be the first of many presentations and trainings on *DC: 0–3*. In preparation for the meeting, I developed a diagnostic decision tree. This helped to clarify that *DC: 0–3* could offer clinicians guidelines for recognizing traumatic stress disorder in very young children, problems in regulation between parents and babies (sometimes because the baby had constitutional or maturational problems), and disordered relationships that might be creating problems within the dyad. As the final *DC: 0–3* system evolved, the decision tree remained an essential part of the diagnostic process, reminding clinicians not to overlook potentially important clues (www.zerotothree.org/imh).

Since its publication, *DC: 0–3* has become widely accepted as a diagnostic system. Familiarity with *DC: 0–3* is required of candidates for board certification in child and adolescent psychiatry, and the system is a required part of training in developmental and behavioral pediatrics (DBP; I served as a member of the DBP sub-board during the development of the specialty qualifications and helped influence that decision). Every year, Jean Thomas, a child and adolescent psychiatrist and Graduate ZERO TO THREE Fellow, others, and I offer an introductory all-day forum on *DC: 0–3* at ZERO TO THREE's National Training Institute. Jean and I also present the system each year at the American Academy of Child and Adolescent Psychiatry's Annual Meeting.

In Colorado, we have been using *DC: 0–3* in our clinical settings for some time. As third-party payers in Arizona, Colorado, Florida, Maine, Ohio, Texas, and Washington state have begun to accept some or all of *DC: 0–3*, several of us have traveled the country providing statewide training. But no good deed goes unpunished. Last year, in the Miami airport, security guards in war-on-terrorism mode confiscated my pointer and training videotape from my briefcase. At 6 a.m., neither they nor I were very collegial in our problem-solving. Finally, I got the tape back and the pointer (without the batteries) and made my flight. My hands weren't too bruised from the handcuffs.

The Influence of Irving Harris

A ZERO TO THREE tradition that turned out to be very important to me was the alphabetical seating arrangement of Board members at meetings. This system placed me regularly next to Irving Harris. Who was this guy? He wasn't a child psychiatrist, psychologist, or developmentalist. Something about Toni home permanents and smoke detectors? Why would there be anyone other than a professional in the field on the ZERO TO THREE Board? After sitting next to him at several meetings, I finally asked Irving what brought him to ZERO TO THREE. He told me that he had retired from business and had been influenced by René Spitz among others. The more I got to know Irving, the more impressed I was with his passion for and knowledge about young children and their developmental needs (see Harris, pp. 41–43, this issue). Several years later, Irving asked me about establishing a program for infant mental health training in Colorado. This conversation eventually led to the creation of the Irving Harris Program in Child Development and Infant Mental Health (Harmon, 2002), a part of the larger Harris Professional Development Network.

Our training program (Harmon & Frankel, 1997) is now beginning its eighth year. We provide full-time, intensive training for 2–3 postdoctoral fellows each year, who receive intensive clinical training at a community-based site. In addition, we provide 3–4 hours of weekly individual supervision and a series of seminars, including group supervision. We have also developed a "mid-career" training track, allowing individuals who are currently working in the field of infant mental health to receive a focused training experience as well as faculty supervision of their work in their current position. They also attend the seminars with the full-time fellows. We currently have trained (including the current fellows) 18 full-time postdocs (PhD, PsyD, child psychiatry), and 9 mid-career postdocs (MSW, LPC, OT, PT). More information on our training program can be found at www.uchsc.edu/sm/psych/dept/training/harris.htm.

When the Harris Program began, I had already become Director of the Kempe Therapeutic Preschool (Harmon & Riggs, 1996) for physically and sexually abused young children. The preschool was a difficult but enriching training site for individuals interested in young children and infant mental health as we defined it. My experience treating Sally influenced our treatment approach. We provided intensive individual treatment for children, almost all of whom met criteria for Traumatic Stress Disorder in *DC: 0–3* or Post-Traumatic Stress Disorder according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). We focused on adaptive play reenactment rather than post-traumatic play. In addition, a safe and predictable milieu, intensive work with families, and medication when indicated proved to be useful.

The funding of the Harris program also allowed me to begin to consult to and eventually become the Psychiatric

Director of the Haven Residential Therapeutic Community for women recovering from drug addiction, some of whom had been convicted of felonies. Some of the residents had babies, so what better training for a Harris Fellow than trying to help these mothers and babies develop emotional healthy relationships while the mothers were learning how to live clean and sober? In this peer-run program, however, women were often loudly confronted ("trimmed" or "put on the wall" in drug treatment lingo). During one of my early visits to the Haven, I noticed that a mother was trying to feed her baby while being verbally disciplined. I watched the baby react with fear and withdrawal at the loud directives. In addition, mothers of newborns had no special "bonding" time with their babies that was protected from treatment disciplines.

My experiences in the Bethune Center came back to me. I began to talk with the staff about how to keep the babies safe while their mothers were being disciplined. With my help, the child-care staff did an "ecological review" of the mother's day. This exercise resulted in major changes in the mothers' and babies' routines (with no decrease in treatment effectiveness). Just this summer, our continued involvement with Haven has helped facilitate a "mothers-only" treatment house for pregnant women and women with very young children. With the expansion of the program, we are not only taking more women into this specialized program but have space for some older siblings to join their mothers in treatment.

Finally, to come full circle from the days at the Mary McLeod Bethune Infant Education Center, we began to provide mental health consultation to Early Head Start (EHS) programs in Denver. One of the first Harris Fellows to consult to an EHS program has become a permanent, full-time member of the program staff, integrating the concepts and wisdom of infant mental health into the provision of child care and family support.

Thirty Years and Counting

Obviously, I am a fortunate man who has found many mentors along my professional path. I often think that I couldn't have designed better experiences for preparing myself to become an infant mental health clinician than those I managed to serendipitously encounter along the way. I am acutely aware of and try to pass on the importance of mentorship; reflective supervision; trust in your students; and an openness to what infants, toddlers, and their families can teach you if you will watch, listen, and not judge.

REFERENCES

Ainsworth, M. D. S. (1973). The development of infant–mother attachment. In B. Caldwell & H. Ricciutti (Eds.), *Review of child development research* (Vol. 3, pp. 1–94). Chicago: University of Chicago Press.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Bowlby, J. (1969). *Attachment and loss, Vol. 1. Attachment*. New York: Basic Books.

Davis, D. L., Stewart, M., & Harmon, R. J. (1989). Pregnancy after perinatal death: Perspectives on doctor's advice. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 481–487.

Emde, R. N., Gaensbauer, T. J., & Harmon, R. J. (1976). Emotional expression in infancy: A biobehavioral study. *Psychological Issues Monograph, 10*,(1, Serial No. 37). New York: International Universities Press.

Emde, R. N., & Harmon, R. J. (1972). Endogenous and exogenous smiling systems in early infancy. *Journal of the American Academy of Child Psychiatry, 11*, 177–200.

Emde, R. N., Harmon, R. J., Metcalf, D. R., Koenig, K. L., & Wagonfeld, S. (1971). Stress and neonatal sleep. *Psychosomatic Medicine, 33*, 491–497.

Emde, R. N., McCartney, R. D., & Harmon, R. J. (1971). Neonatal smiling in REM states, IV: Premature study. *Child Development, 42*, 1657–1661.

Fraiberg, S. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. *Journal of the American Academy of Child Psychiatry, 14*, 387–422.

Gaensbauer, T. J., & Harmon, R. J. (1982). Attachment behavior in abused/neglected and premature infants: Implications for the concept of attachment. In R. N. Emde & R. J. Harmon (Eds.), *The development of attachment and affiliative systems* (pp. 263–279). New York: Plenum Press.

Gaensbauer, T. J., Mrazek, D., & Harmon, R. J. (1981). Behavioral observations of abused and/or neglected infants. In N. Frude (Ed.), *Psychological approaches to the understanding and preventions of child abuse* (pp. 120–135). London: Batsford.

Greenspan, S. I., & Wieder, S. (2003). Infant and early childhood mental health: A comprehensive developmental approach to assessment and intervention. *Zero to Three, 24* (1), 5–13.

Harmon, R. J. (2002). The administration of programs for infants and toddlers. *Child and Adolescent Psychiatric Clinics of North America, 11*(1), 1–21.

Harmon, R. J., & Emde, R. N. (1972). Spontaneous REM behaviors in a microcephalic infant: A clinical anatomical study. *Child Development, 34*, 827–833.

Harmon, R. J., & Frankel, K. A. (1997). The growth and development of an infant mental health program: An integrated perspective. *Infant Mental Health Journal, 18*, 126–134.

Harmon, R. J., Glicken, A. D., & Siegel, R. E. (1984). Neonatal loss in the intensive care nursery: Effects on maternal grieving and a program for intervention. *Journal of the American Academy of Child Psychiatry, 23*, 68–71.

Harmon, R. J., Morgan, G. A., & Glicken A. D. (1984). Continuities and discontinuities in affective and cognitive motivational development. *International Journal of Child Abuse and Neglect, 8*, 157–167.

Harmon, R. J., Morgan, G. A., & Klein, R. P. (1977). Determinants of normal variation in infants' negative reactions to unfamiliar adults. *Journal of the American Academy of Child Psychiatry, 16*, 670–683.

Harmon, R. J., & Riggs, P. D. (1996). Clonidine for posttraumatic stress disorder in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1247–1249.

Harmon, R. J., Stull, P. J., Emde, R. N., Siegel, C., Kempe, R. S., Margolin, M. H., et al. (1990). Unresolved grief: A two-year-old brings her mother for treatment. *Infant Mental Health Journal, 11*, 97–112.

Harmon, R. J., Suwalsky, J. D., & Klein, R. P. (1979). Infants' preferential response for mother versus an unfamiliar adult: Relationship to attachment. *Journal of the American Academy of Child Psychiatry, 18*, 437–449.

Harris, I. B. (2003). A view of early childhood development. *Zero to Three, 24*(1), 41–43.

Jennings, K. D., Harmon, R. J., Morgan, G. A., Gaiter, J. L., & Yarrow, L. J. (1979). Exploratory play as an index of mastery motivation: Relationships to persistence, cognitive functioning, and environmental measures. *Developmental Psychology, 18*, 386–394.

Lally, J. R. (2003). Infant–toddler child care in the United States: Where has it been? Where is it now? Where is it going? *Zero to Three, 24*(1), 29–34.

Spitz, R. A. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child, 1*, 53–74.

Spitz, R. A. (1946). Anaclitic depression: An inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child, 2*, 313–342.

Spitz, R. A. (1959). *A genetic field theory of ego formation*. New York: International Universities Press.

Yarrow, L. J., & Harmon, R. J. (1975). Maternal deprivation. In A. M. Freedman, H. I. Kaplan, & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry II* (pp. 2278–2283). Baltimore: Williams and Wilkins.

ZERO TO THREE. (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Arlington, VA: Zero To Three/National Center for Clinical Infant Programs.

INFANT–TODDLER CHILD CARE IN THE UNITED STATES:

Where Has It Been? Where Is It Now? Where Is It Going?

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As ZERO TO THREE celebrates its 25th anniversary, thinking back on its history led me to reminisce about the history of my specialty: infant–toddler group care. It was my work in infant care and home visitation that brought me together with the other founders of ZERO TO THREE.

The Mental Health Study Center

When I was invited in 1974 to join in twice-yearly discussions of infants and their needs at the National Institute of Mental Health's Mental Health Study Center, I leapt at the chance. I was searching for colleagues with whom to discuss infant development—people who agreed that what happened to infants was of utmost importance to society. Little did I know that I would stay with this group for 30 years, during which I helped found the organization that was known first as The National Center for Clinical Infant Programs and later as ZERO TO THREE.

In the early 1970s, several researchers were studying infants, but we were working in many different disciplines. We didn't get a chance to hear each other frequently. Those early Study Center meetings let us talk about how we were relating to infants and toddlers in homes, clinics, offices, child-care programs, and hospitals. Clinical research was shared with quantitative researchers, applied research with basic researchers, pediatric medicine with developmental psychologists, and so on. Each of us wanted to have others in the group hear our current hypotheses about early development and how to support it and to critique our ideas before we launched them in public. Just as strongly, each of us wanted to hear about our colleagues' work. Because of my interest in child care, I was particularly attentive to what colleagues had to say about babies in groups. I wanted to know about temperament in group settings, the altruism of a 2-year-old in the presence of other 2-year-olds, the influence of the group on

at a glance

- Informal care accounts for about half of all infant–toddler child care arrangements in the US.
- Periodic legislative efforts to create formal systems of publicly funded infant–toddler child care have not succeeded.
- Thanks to the federal Child Care and Development Fund, every state is moving toward better-quality infant–toddler child care
- High-quality infant–toddler child care requires responsive professionals who are well trained, compensated, and supported.

the socialization process of an individual child, and the impact of groups on intellectual development. I also wanted to talk about the care of infants and toddlers who came from families with little money and limited education. After almost a decade of work with such families, I had strong, research-backed beliefs about what could be done to support their children's healthy development. I wanted to hear what other professionals thought about the potential of intervention programs that worked directly with children in child care and indirectly but intensively with their families.

Those Study Center meetings affected us all profoundly. We soon realized that we couldn't just sit around a table and talk with each other; what we were discussing was too important to the future of our country's children. We envisioned a coordinated effort in which all disciplines serving infants, toddlers, and their families could share their research and ideas with each other, with policymakers, and with the general public—where everyone could learn about the competence and vulnerability that exist side by side in infants. In 1977, we founded ZERO TO THREE.

Research-driven best practice recommendations are incompletely implemented in much of the child care available to infants and toddlers in this country.

Living the History of Infant–Toddler Child Care in the United States

Our discussions at the Mental Health Study Center and at Board and scientific meetings after ZERO TO THREE was launched helped write the history of infant care in the United States. We formulated key concepts that are now a part of best practice recommendations—for example, the importance of continuity of relationships among parents, teachers, and children; attachment to primary caregivers; reading infants' cues; the need for attention to individual children's sensitivities and temperamental characteristics in group care; the interrelatedness of developmental domains; and the role of day-to-day encounters in shaping the child's development of a sense of self.

Even after a quarter of a century, however, these research-driven best practice recommendations are, to say the least, incompletely implemented in much of the child care available to infants and toddlers in this country. A brief review of the history of infant–toddler child care in the United States should help explain how we have arrived at our current situation.

Infant–Toddler Child Care Before 1960

Parents have always shared the care of their infants and toddlers with others. They have recruited relatives, friends, and neighbors to take care of their babies. Some informal caregivers do a wonderful job, but others function as "baby-sitters," with no training and little motivation to encourage the child's development. In the United States today, informal care accounts for about half of all infant–toddler care. Many believe that the existence of the informal system keeps infant–toddler care from being viewed as a profession. Interestingly, at several points in the history of infant–toddler care in the United States, it looked as if a more formal system would supplant informal and unregulated child care.

The first time this occurred was when World War II stimulated the growth of quality child-care programs for infants and toddlers in the United States. Businesses and factories needed women in the workforce; to get them there corporations provided quality care for their children. Kaiser Corporation, for example, provided first-rate care for the children of women working on its shipbuilding production lines. Kaiser's directors were convinced that quality child care required well-trained teachers; well-designed, safe, and healthy facilities; and appropriate ratios of teachers to toddlers. Kaiser even provided hot meals for mothers to pick up, along with their children, at the end of their shift. Other corporations followed Kaiser's example.

After the war, however, these services vanished. Mothers, relatives, friends, and neighbors took care of very young children. These informal arrangements continued to work because trusted people were available for the care of the children who needed it—and because few non-minority mothers of young children were in the workforce.

Even in 1960, 15 years after the end of the war, only about one in six mothers with children younger than age 1 year worked outside the home. By 1970, almost one quarter (24%) of mothers with children younger than age 1 were in the workforce; by 1984, almost half (47%) of these mothers worked outside the home (Bureau of Labor Statistics, 1994). In 25 years, the increase in babies needing child care had overwhelmed the informal system.

Turning Points—The 1970s

In response to the massive shifts in workforce participation by women and the erosion of informal neighborhood and family supports in the early 1970s, most industrialized nations instituted formal support systems for families. They passed laws to subsidize and regulate child care, provide paid parental leave during the first year of life, guarantee liberal leave for the care of sick children, and provide universal child health care or health insurance.

After studying the same social trends, the U.S. Congress tried to help American families. Sponsored by Senator Walter Mondale (D-MN) and Congressman John Brademas (D-IN), the Comprehensive Child Development Act, which included $700 million for high-quality child care for poor Americans and $50 million for child-care facilities, was passed in 1971. The bill was sent to President Richard Nixon for his signature. Officials at the Department of Health, Education, and Welfare (DHEW) were so sure that

the bill would become law, because of its broad bipartisan support, that they quickly convened 125 child development experts and cloistered them at Airlie House Conference Center in Virginia for a week. There, they worked around the clock to develop a series of booklets that were to be the blueprint for the new national family support system. The booklets probably still remain in the lower basements of the Department of Health and Human Services (the successor to DHEW), waiting for the enactment of such a system (see Weissbourd and Lombardi, pp. 51–56, this issue).

What happened next shocked the child-care community. President Nixon vetoed the act, dismissing it as "the most radical piece of legislation to emerge from the 92nd Congress" and moving "the vast authority of the federal government to the side of communal approaches to child rearing over the family-centered approach" (Nixon, R.M., 1971, December 10, Congressional Record, S21129). This veto was the single most significant act in the history of infant–toddler child care in the United States. It separated our country from the rest of the industrialized world by leaving responsibility for child care with individual families rather than recognizing society's stake in, and responsibility for, investing in early childhood development. The veto further separated "child care" from "early childhood education." As a result, most citizens continued to equate child care with baby-sitting.

In 1971, President Nixon vetoed the Comprehensive Child Development Act, saying that it would move "the vast authority of the federal government to the side of communal approaches to child rearing over the family-centered approach."

To Be or Not To Be: The Creation of a Profession

Professionals interested in early childhood development agreed that "baby-sitting" did not describe what was needed in out-of-home care, but they agreed on little else about caring for infants and toddlers in groups. Two different philosophies influenced professional thinking in the 1960s and 1970s. The first emerged from the cooperative schools that had sprung up on many college and university campuses across the country. Middle- and upper-middle-class parents and married students brought their preschool-age children to a center a few times a week, for a few hours each visit, so that they could play and socialize with other children. Parents and students, often from the College of Home Economics, created interesting play spaces and materials for the children to use and designed long-term projects for the children. A few of these programs included toddlers.

The second philosophy that developed at this time was a form of cognitive early intervention. Behaviorally oriented professionals designed cognitively focused early group programs, usually connected with universities, for the children of the poor or "disadvantaged." They hoped to "break the cycle of poverty" in a way that Head Start had not been able to in its first years. Intellectual stimulation was the order of the day; the programs usually provided developmentally sequenced "enriched learning activities," taught in sequence to the children. As with the cooperative schools, these programs were much more prevalent for preschool-age children, but a few were designed for infants and toddlers.

Right from the start, these two schools of thought fought the battle between "play" and "intellectual rigor" that still rages today: Which best readies children for school and life?

I remember a program in the early 1970s in Kansas whose leaders viewed the baby in care as an object to be dealt with effectively and efficiently. Teachers were stationed in different parts of the classroom to perform specific activities. One person was responsible for diapering and feeding, another for intellectual stimulation, another for physical development, and so on. The notion of relationship was nowhere to be found. I also remember heated conversations with cooperative school advocates who insisted that adult attention to babies' and toddlers' intellectual development had no place in child-care programs.

A few visionaries tried to turn this debate into a dialogue. These included, among others, Susan Gray from the DARCEE program at George Peabody College; Mary Elizabeth Keister from the family child-care program at the University of North Carolina–Greensborough; Ira Gordon from the Parent Education Project at the University of Florida; Kuno Beller from the Infant–Toddler Program at Temple University; Henry Ricciuti from the Infant–Toddler Center at Cornell University; David Weikart from the Infant Parent Program in Ypsilanti, Michigan; and Phyllis Levenstein from the Long Island Home Visitation Program. These men and women saw that very young children's play and intellectual development went together. They recognized that attention to social and emotional development, parent–provider partnerships, and opportunities for economic advancement and education for adult family members should accompany attention to intellectual development. All of these pioneers studied and wrote about their work and greatly influenced the thinking of the field.

I believe that the most influential members of this group of pioneers were Bettye Caldwell, Julius Richmond, and Alice Honig of the Syracuse University Children's Center. In 1964, they started the first federally funded infant care program in the country. Their center attracted hundreds of visitors a year and a great deal of media coverage. This publicity, combined with the founders' visibility as researchers and public speakers, served to make caring for infants in groups a topic for serious academic discussion.

Also in the late 1960s and early 1970s, the study of infant care was becoming active and intense. Journals such as the *Merrill-Palmer Quarterly* published articles about the impact

of the early years on later development, often discussed in the context of poverty and ethnicity. Charles Gershenson, Director of the Children's Bureau, DHEW, assembled some 50 university-based researchers to advise the federal government on appropriate services for infants, toddlers, and their families over a 5-year period. This group, nicknamed "Up Start" by Irving Lazar of Cornell University, brought infant care to the attention of Congress. It also helped spark the development of federally funded initiatives for low-income families with infants and toddlers such as the Parent Child Centers, Home Start, and Child and Family Resource Programs. All of these programs paved the way for today's Early Head Start (EHS).

Despite recommendations from researchers and discussion in Congress, little change in infant care policy or practice occurred. Families were on their own, finding and paying for care in settings that were mostly unregulated. The question for researchers continued to be, "Is day care harmful to babies?" It was studied again and again in those decades—as it is today. How data were interpreted almost always depended on the politics of whoever was doing the interpreting. During this period, many of the "visionaries" mentioned above were asking a different question. They said, "Day care is here to stay—so how can we make it better?" It was their efforts that advanced the field.

Popular opinion held that, because child care would never achieve adequate quality, middle- and upper-middle-class families should be discouraged from using it for their infants and toddlers. Poor parents, on the other hand, should be encouraged to use day care so that they could work or participate in job training. But, if public funds were to be used to subsidize day care for low-income families, the thinking went, the cost of care should be kept as low as possible. Untrained caregivers would be good enough.

Policymakers who were concerned about setting—and enforcing—child-care standards of quality looked for elements of group care for children that were not only associated with favorable outcomes for children but could also be measured and regulated. The 1979 National Day Care Study (NDCS; Ruopp, Travers, Glantz, & Coelen, 1979) strongly suggested that small groups of children, a low child–staff ratio, and lead caregivers who had training in child development were such regulatable elements. In that same year, pediatrician Sally Provence, a founding Board member of ZERO TO THREE, testified before Congress about the importance of having no more than three infants or toddlers assigned to one caregiver. (A firefighters' association representative endorsed the same child–staff ratio, but for somewhat different reasons.) The Federal Interagency Day Care Requirements (FIDCR), passed by the Congress in 1980, adopted most of the NDCS suggestions. But after President Ronald Reagan turned child care over to the states early in 1981, federal day care requirements were largely moot. And a 1986 survey of state child-care requirements found that only three states conformed to the caregiver–infant ratios recommended in FIDCR (Morgan, 1987).

During the 1980s, as more parents needed infant–toddler child care, there was a growing and desperate clamor for more and better services. I remember interviewing a woman in 1981 who said, with tears in her eyes,

> *At the moment I'm desperately looking for child care, and it's really difficult. It puts a tremendous amount of stress on me because I feel very guilty about putting my child in any kind of situation that isn't really perfect. And since my options are all pretty mediocre, it's very difficult because I feel that I might be doing something that could cause my child to be unhappy or ultimately could, I suppose, damage my child. That makes me feel very guilty as a parent about putting my child in child care. And it is not the fact that I'm putting my child in someone else's hands—it's the hands I'm forced to chose from.* (Lally, 1981, p. 11)

In the mid-1980s, Congressman George Miller (D-CA) heard the whole spectrum of opinion and concern about child care and other family issues. He created the Select Committee on Children, Youth, and Families to look into the problems facing American families. His able staff, led for much of the Committee's existence by Anne Rosewater, brought scores of parents and professionals to Washington to testify about what children and families needed and what might be done. Miller brought babies, families, and child care back to the attention of Congress and the public. One result of his efforts to make the needs of families visible was a bill introduced in the 1987–88 session of Congress, the Act for Better Child Care (ABC bill), sponsored by Senator Christopher Dodd (D-CT). Education groups, child advocacy and welfare associations, labor unions, and nearly 200 cosponsors in the House and Senate supported the ABC bill, but neither that bill nor any other significant child-care legislation was passed. The only bill enacted in these years that supported child care was the1988 Welfare Reform Act, which contained a child-care provision because the act required welfare recipients to seek employment even before their children were old enough to enter kindergarten.

Once again, parents and day care providers were left to their own devices to solve the child-care problem or look to their states for help. It was not until the mid-1990s and the passage of the Child Care and Development Block Grant (CCDBG) Program and EHS that the federal government weighed in with any significant help. In 1995, the Child Care Bureau was created to enhance the quality, affordability, and supply of child care available for all families.

The Present

The single *positive* thing that most changed the landscape of infant–toddler child care in the United States was the infant–toddler "set-aside" provision of the CCDBG, passed in 1990. States were able to use their share of $100 million set aside within the overall CCDBG budget to improve the quality of their infant–toddler child-care programs. With

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This special plenary session will describe specific research efforts focused on the study of the etiology, early diagnosis and treatment of autism.

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- Psychopharmacology for Young Children
- Addressing Maternal Depression

Sunday, December 7th
Practice Plenary - The Zero in "Zero to Three": Outreach and Continuity with Families in Pregnancy, at Birth and Beyond
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- Reflective, Relationship-Based Supervision: An Exploration of Roles
- Better Baby Care: Defining and Delivering Quality

Or one-of-a-kind Post-Institute Intensive Dialogue sessions on Sunday, December 7th.

- *DC: 0-3*
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❑ Check here if you have special needs that require accommodation in order for you to fully participate. ZERO TO THREE encourages and welcomes all who work with infants, toddlers and their families to NTI. A member of our staff with contact you prior to the conference to make appropriate arrangements for your participation.

OVER ➤

Field Presentations/Symposia Selections

Please mark your first, second, and third choice in each time slot.

Friday, Dec 5
11:00 am – 1:00 pm

_ (A1) Field - The Power of the Relationship...Treating Traumatic Bereavement
_ (A2) Field - An Introduction to Reflective Practice
_ (A3) Field - Lessons from the Field: Mental Health...Early Head Start
_ (A4) Field - New Perspectives on Parenting Education
_ (A5) Field - Implementing Continuity of Care
_ (A6) Field - Teaming for Success...Cultural and Linguistic Relevancy
_ (A7) Field - Lessons from Ground Zero
_ (A8) Sym - Issues in Child Welfare (Part 1)
_ (A9) Sym - DIR...Assessment and Intervention
_ (A10) Sym - Observation, Reflection, and Discussion

Friday, Dec 5
2:30 pm – 4:30 pm

_ (B1) Field - Sierra's Secure Base
_ (B2) Field - IMH in Early Head Start
_ (B3) Field - Resiliency and Relationship-Based Intervention
_ (B4) Field - Vital Links...Families, Health Care, and Early Intervention Providers
_ (B5) Field - Positive Interventions with Parents Who Have Cognitive Limitations
_ (B6) Field - Addressing the Complex Needs...Foster Care
_ (B7) Field - Crossing the Bridge from Research to Practice
_ (B8) Sym - Temperament
_ (B9) Sym - Focus and Reflect
_ (B10) Sym - Psychotherapy For Young Children Exposed to Family Violence

Saturday, Dec 6
11:30 am – 1:30 pm

_ (C1) Field - Stressed Families: The Impact of Homelessness
_ (C2) Field - Supervision as a Vehicle for Supporting Staff Development
_ (C3) Field - Attachment Disorders in Maltreated Twins
_ (C4) Field - Communities of Practice...Building the Evidence Base
_ (C5) Field - Reaching Out to Young Children At-Risk
_ (C6) Field - The Action Is in the Interaction...Family Dynamics
_ (C7) Sym - An Introduction to the CLNBAS
_ (C8) Sym - Good Night Moon and Beyond: Early Literacy Experiences...
_ (C9) Sym - Issues in Child Welfare (Part 2)
_ (C10) Sym - An Assessment Guide on Father Inclusive Practices

Saturday, Dec 6
3:15 pm – 5:15 pm

_ (D1) Field - Useful Tools for Helping...with Distress
_ (D2) Field - Experiences in Providing IMH Services
_ (D3) Field - Changing Policy and Practice...the Judicial and Child Welfare Systems
_ (D4) Field - Innovative Strategies for Personnel Development
_ (D5) Field - A Year of Treatment for a Toddler with Autism
_ (D6) Field - Music Therapy and Early Intervention
_ (D7) Field - Fetal Alcohol Syndrome
_ (D8) Sym - Psychopharmocology for Young Children
_ (D9) Sym - Examining Cultural Themes in Parenting Strategies
_ (D10) Sym - Addressing Maternal Depression

Hot Topic Networking & Discussion Groups

Please select 3 topics of interest to you. A total of 6 topics will be selected from among those most popular with NTI registrants.

❑ Assessment/Screening
❑ Attachment
❑ Autism/Autistic Spectrum Disorders
❑ Breastfeeding/Feeding Issues
❑ Child Abuse Prevention/Treatment
❑ Child Welfare
❑ Culture/Diversity
❑ Early Brain Development – Training
❑ Early Brain Development – Uses of Research
❑ Early Literacy
❑ Evaluation/Quality Improvement
❑ Inclusion/Natural Environments
❑ Infant Mental Health – Practice
❑ Infant Mental Health – Systems
❑ Infant Mental Health – Training
❑ Infant/Family Program Leadership
❑ Male Involvement in Infant/Family Programs
❑ Observation
❑ Parent-Child Relationship Building
❑ Policy/Advocacy
❑ Reflective Supervision
❑ School Readiness
❑ Training - Distance Education
❑ Training – Pre-service & In-service
❑ Trauma/Child Witness to Violence
❑ Welfare-to-Work

Tell Us A Little About Yourself

Please share your discipline and background with us so that we can better meet your needs!

A. Your Profession
❑ Child Psychiatrist
❑ Early Childhood Educator/ Child Care Provider
❑ Early Intervention Provider/Special Educator
❑ Family Support Worker
❑ Nurse
❑ Occupational Therapist
❑ Parent Educator
❑ Pediatrician
❑ Physical Therapist
❑ Psychologist
❑ Social Worker
❑ Speech Pathologist
❑ Other (specify)

_____

B. Your Primary Job Function
❑ Administrator
❑ Child/Family Advocate
❑ College/University Faculty
❑ Direct Service Staff
❑ Home Visitor
❑ Parent
❑ Private Practice Consultant
❑ Service Coordinator
❑ Supervisor/Manager
❑ Training/Technical Assistance Provider
❑ Other (specify)

_____

C. The Setting/Area In Which You Work
❑ Child Care/Early Care Home-based
❑ Child Care/Early Care Center-based
❑ Child Welfare/Foster Care
❑ Early Head Start
❑ Early Intervention
❑ Family Support
❑ Hospital
❑ Judicial System
❑ Mental Health
❑ Primary Health Care
❑ Private Practice
❑ Social Service/ Community Agency
❑ University/College
❑ Other (specify)

_____

D. Your Years in Practice
❑ 1
❑ 2-3
❑ 4-7
❑ 8-10
❑ More than 10

E. Your Highest Educational Level
❑ High School Diploma
❑ Associate Degree
❑ Bachelor's Degree
❑ Master's Degree
❑ Doctoral Degree
❑ Other (specify)

_____

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these new federal dollars, states went about the business of identifying and improving child-care quality.

The result, as of 2003, is movement toward better-quality infant–toddler child care in every state. Some states are developing training systems; others are rethinking and changing program requirements, such as ratios and total group size; and still others are creating model centers and new technical assistance systems. Since the inception of the CCDBG Program (now the Child Care and Development Fund; CCDF) and its infant–toddler set-aside, the question asked by the pioneers of infant toddler child care—"Day care is here to stay—so how can we make it better?"—is being asked by all the states of the union.

Another bright spot of this past decade has been the development and expansion of EHS. Since its launch in 1995 with 68 programs through its expansion in 2003 to almost 700 programs, EHS has sought to raise the standard of out-of-home care for infants and toddlers in low-income families in the United States. The Head Start Bureau has developed performance standards for its programs that serve children from birth to 5 years that include primary caregiver assignments, small groups, continuity of relationship between caregivers and children, individualized programming, and attention to family and culture. EHS has developed a training and technical assistance structure to encourage continuous improvement of the quality of care provided to babies, toddlers, and pregnant women.

The past decade has seen significant growth in state and federal attention to the quality of child care for infants and toddlers. Yet the quality of group infant care remains in jeopardy. Providers are still leaving the field in droves because of poor pay, low status, and lack of job security. Men continue to bypass the field not only because of salary concerns but also because of the suspicions of a society that questions the idea of men working with babies.

As states are asked to subsidize the child-care needs of more families, and to do so in the context of huge budget deficits, policymakers are scrutinizing the costs of infant–toddler care. Lawmakers view money previously earmarked for infant–toddler quality improvement efforts as a resource that could be used to provide more services of lesser quality. Administrators are examining the regulations that currently set money aside exclusively for infant–toddler care, hoping to find language that might permit use of the funds for older children. One major effect of the budget crunch is a decrease in the number of quality centers. Because providers cannot offer quality infant–toddler care at the level of subsidy allotted by the states, subsidized infant–toddler programs across the country are closing. Additionally, services for the poor are being provided at a low level of quality by providers with little training, particularly for those receiving Temporary Assistance to Needy Families (TANF) assistance and those just above poverty level.

It is ironic and unfortunate that states, for economic reasons, are developing waivers that allow more and more infant–toddler programs to bypass the states' own newly instituted quality recommendations (such as the various state guidelines for infant–toddler care that have been produced as part of CCDF initiatives) to find providers for TANF families. At a time when states are growing in their understanding of and commitment to quality child-care services for infants and toddlers, these waivers allow intolerable differences in quality standards based on the economic background of infants and toddlers. Often the children who need the highest quality of service (because of economic, community, or family risk factors) receive the lowest quality. After all the work and progress in the past decade, there is still the inclination, when economic times get hard, to allow caregivers with limited or no training, questionable motivation for the work, and no supervision to care for children.

ADRIENNE BRIGMON SPARGER

What is true now has always been true. The care that infants and toddlers need is different than the care that preschoolers and school-age children require. If federal, state, and local governments, businesses, or a combination of these cannot subsidize infant–toddler care, there will not be adequate care for our infants and toddlers. It has been demonstrated again and again that the average parental income cannot even begin to pay for child care of the quality needed for healthy infant growth and development. The United States is the last industrialized nation to come to grips with this reality. This is particularly frustrating because we now know more than ever before about what very young children need and how to give it to them. At the same time, through CCDF, EHS, and many exciting new state initiatives, we have begun to develop a structure to support and sustain quality care. But it still seems that when economic times get tough, even in 2003, it is the baby that pays the cost.

The Future: Where Will Infant–Toddler Care Go?

The field of infant–toddler child care has advanced since the 1960s and 1970s, but it is doing so slowly and with many setbacks along the way. Some form of infant child care will be part of the fabric of American life well into the distant future, but rather than optimizing child care for babies and toddlers, we treat it as if it will go away! In the process, infants pay the cost of our lack of attention. If we are going to have infant care, then why not create places where babies love to go and we love to have them go? Instead of setting our sights so low, why not create places where our children will be amazed, enlivened, and overjoyed each day? Why stop at "Do no harm!"

Here are four recommendations that will help reach that vision.

1. *Build the profession.* Separate care by family and friends from educational experiences for infants and toddlers in groups provided by professional educators. The child-care profession should be more than a support to family and friends that provides care while a parent is working—it should also provide the family with an educationally unique service.

Staff at centers and family day care homes will be educators, not baby-sitters, and will be expected to conduct themselves as paid, credentialed professionals who not only keep children safe and healthy but also facilitate social, emotional, and intellectual learning. Infant care should be presented as a supplement to family activities—an enrichment of the child's experiences. In Europe, many families try very hard to get their 12-month-old children into such programs so the babies can engage in social and learning experiences that are available in these centers but are not available at home. The distinction of roles – family care and professional educators—must be clear and widely disseminated.

2. *Develop a responsive approach to curriculum.* Notions of curriculum implementation for infants and toddlers need to change radically from those in current practice. The inclinations of inadequately trained caregivers to provide only tender, loving care with attention to health and safety are not enough. Neither is care from caregivers who, also inadequately trained, follow a prescribed curriculum as a crutch regardless of a child's interest because they don't feel capable of reading and responding to the child's cues without the safety net of preset lessons.

It is time for practice to catch up with theory. The best programs train teachers to observe each child in action, document the child's interests and capabilities, and develop and adapt their own efforts on the basis of the child's interests and learning strategies. Teachers need to be active without being intrusive. The responsive professional carries out sophisticated interactions with children, such as isolating elements of a problem so they can see its components more clearly, setting up environmental conditions that help them focus their observations, and introducing materials and experiences that are based on child observation and that challenge and expand their initial understanding.

3. *Provide training and contemplative time.* To do the kind of work described above, ongoing training should be a guaranteed part of any child-care system. Professional growth is essential for teachers to reach a point of competence where they feel secure enough to observe and adapt their work to the changing needs of children in their care, partner with families from varying cultures and conditions, and include children with special needs in every aspect of their programs.

In addition, teachers need time to contemplate their own efforts individually, with peers, and with supervisors. Time should be set aside each week for educators to review their documentation of day-to-day events, think about the progress of the children in their care, discuss their thoughts with peers and supervisors, and plan adaptations based on their analysis.

4. *Increase the visibility of the payoff of infant–toddler care to the larger community.* The importance of the first 3 years of life and the experiences of children who spend up to 10 hours per day in out-of-home care need to become everyone's concerns. This can and should be done by organizations like ZERO TO THREE and the National Association for the Education of Young Children and by state and federal governments. These organizations can show the benefits of placing children in well-conceptualized, well-staffed, and well-run programs. But the most important communicators of this information should be the programs themselves.

I have personally witnessed the development of infant–toddler child care in the United States since 1966. The history that I have just described may not be a complete history, but it is the one I have experienced. I'm sure others may have seen things differently. For me, these past almost-40 years have been an up-and-down, emotional experience. I have been deeply discouraged by the many times we as a country have backed away from chances to improve care of our youngest children. I have been excited about the advances we have made in understanding who babies are and how their growth is best facilitated. I have been awed by the dedication of providers doing the best they can for babies, shouldering on in the face of impossible odds.

As I write this, I see that we are at a decision-making point once again. Can we build on the recent advances of CCDF and EHS, or will we drop back? I feel excitement tinged with sadness as I look to the future of infant–toddler care in the United States. I don't know what the future holds—and I expect someone else will write its history.

REFERENCES

Bureau of Labor Statistics, Department of Labor. (1994). *Working mothers reach record numbers in 1984*. Washington, DC: Author.

Lally, J. R. (1981). *Infant, toddler, and preschooler mental health: Information for families with mothers who work outside the home*. San Francisco: Far West Laboratory for Educational Research and Development.

Morgan, G. (1987). *The national state of childcare regulation: 1986*. Watertown, MA: Work/Family Directions.

Ruopp, R., Travers, J., Glantz, F., & Coelen, O. (1979). *Children at the center: Summary findings and implications. Final report of the national day care study*, Vol. 1. Cambridge, MA: Abt Associates.

Weissbourd, B., & Lombardi, J. (2003). The promise of parents as advocates. *Zero to Three*, *24*(1), 49–54.

CARLOS WILLIAM PEREZ

PREPARING INFANT–FAMILY PRACTITIONERS:

A Work in Progress

LINDA EGGBEER *and* TAMMY MANN
ZERO TO THREE
and
LINDA GILKERSON
Erikson Institute

What do we know about building an infant–family workforce that individually and collectively possesses the knowledge, skills, and personal qualities to partner with parents during the first 3 years of a child's life? What have we learned over the past quarter-century about the content and the process of training and professional development in the infant–family field? How far have we come in ensuring that those who interact with infants, toddlers, and families on a regular basis know what they are doing? In this article, we highlight some of the key markers in the field's efforts to build a well-trained workforce, including ZERO TO THREE's efforts in this area. We examine the progress in building and disseminating a knowledge base, both within and across the many disciplines concerned with very young children and families. Finally, we reflect on lessons learned and future directions.

Growing Professional Competence in a New Field

Over the last 25 years, we have witnessed the creation and rapid development of the infant–family field. Many individuals and institutions have created and sustained a multifaceted effort, central to that development, to prepare and support those who work with infants and families. Professional development activities have focused on training individuals from single and from multiple disciplines, reaching those who work in programs and those who practice alone or in small groups, educating those who interact with children and families on a daily basis and those who may see an infant or toddler only once or

at a glance

- A multifaceted effort to prepare and support practitioners who work with infants, toddlers, and families has been central to the growth of the infant–family field.
- Part C of IDEA and Early Head Start have been catalysts for multidisciplinary training.
- ZERO TO THREE has identified 4 elements of training important to all infant–family practitioners: 1) a core knowledge base; 2) opportunities for observation; 3) reflective supervision; and 4) collegial support.

40

twice, and supporting, over time, those individuals who have advanced degrees in early childhood as well as those who have never taken a course nor held a baby. A daunting and complex task, but one the infant–family field has addressed with energy and thoughtfulness.

In the 1970s, the field itself was in its infancy as scientists, educators, and clinicians from a number of disciplines began to communicate about fascinating research findings and new clinical models regarding the first 3 years of life. Exciting training initiatives were already underway, including the Nursing Child Assessment Satellite Training developed at the University of Washington; Minnesota Early Learning Design's training to prepare multidisciplinary facilitators to hold groups for young parents; the Neonatal Behavioral Assessment Scale, used to train health care and other practitioners about the amazing competence of newborns; and interdisciplinary mental health training begun in the Child Development Project in Ann Arbor by Selma Fraiberg.

In the late 1980s, early social and emotional development (infant mental health) emerged as a priority for training and professional development.

Also in the 1970s, the Administration for Children, Youth, and Families of the Department of Health, Education, and Welfare launched the Child Development Associate (CDA), a national effort to improve the quality of childcare by training and credentialing the early childhood workforce. Competencies were established for childcare and Head Start staff serving children ages 3–5 years in center-based programs; training and credentialing soon followed, with the first CDA credentials awarded in 1975. An infant–toddler credential was formalized a few years later. Federal funds became available to develop new summer institutes and initiate short courses devoted to infant–toddler care.

In the 1980s, the focus on infancy broadened to embrace very young children with, or at risk for, developmental delays or disabilities and their families. Federal agencies (primarily the U.S. Department of Education, Office of Special Education Programs) funded the development of new clinical models and training approaches to meet the legislative requirement for adequately trained personnel to provide services to infants and toddlers under Part H (now C) of the Individuals with Disabilities Education Act of 1986. Part H created a new and strong philosophical framework for training and professional development: that of family-centered, strength-based, inclusive services. This paradigm shift required professionals to reexamine their role in relation to the child, the family, and the community. The child's developmental imperative to grow and become competent in interactions within the family and community became a guiding principle in early intervention training.

Because early interventionists worked in a variety of settings, alone and on teams, early intervention leaders defined a set of core competencies and training experiences that transcended settings and disciplines. Furthermore, leaders developed discipline-specific competencies that were incorporated into disciplinary requirements for licensing, credentialing, or certification. Federally funded early-intervention training programs developed effective mechanisms for evaluating the knowledge and skills of infancy practitioners across many disciplines and for defining the appropriate intersection of pre- and in-service training and preparation. Although new federal funding allowed colleges and universities to initiate Master's and post-Master's degree programs, many of the grants supported short demonstration projects and time-limited training models. Federal funding also supported innovative higher-education faculty-training initiatives to build the college and university teachers' knowledge and skills about infancy and to connect them to local or state teams of providers and trainers working to enhance the skills and knowledge of early interventionists.

Some colleges with long histories of educating early-childhood students developed graduate programs specifically designed to prepare students for roles in the growing and changing infant–family field. Four such private colleges (Bank Street College, Erikson Institute, Wheelock College, and Pacific Oaks College) formed a Consortium in the mid-1990s to further their common goal of providing multidisciplinary child development studies based on a developmental approach to learning, a commitment to reflective practice, and an emphasis on developing and preparing child development leaders. Recognition of the complexity and ambiguity of infant–family work led program developers to create small, personalized, guided learning experiences to support student learning.

Toward the end of the 1980s, the critical importance of early social and emotional development (infant mental health) emerged as a priority for training and professional development. The Program for Infant Toddler Caregivers (PITC), funded by the California Department of Education and developed by WestEd, widely disseminated extensive print and video materials for trainers of infant–toddler staff. The guiding principles of the program's approach, including its emphasis on primary caregiving and continuity of care, helped trainees from child care centers and beyond understand the importance of consistent relationships for babies.

The inner experience of the baby and toddler and the centrality of relationships for healthy development continued to be important theoretical, clinical, and training issues for the field in the 1990s. A number of new training programs in infant mental health were launched; many of these were funded by Irving Harris. These programs integrated knowledge from child development, health, mental health, and the neurosciences and offered degrees, fellowships, and

CHANDLER DONNE MARTIN

certificates to advanced trainees. Trainees' new knowledge enabled them to bring infant mental health principles to all infant–family settings and to provide more specialized assessment and intervention for troubled parent–child relationships and for children with social, emotional, or behavioral concerns.

The 1994 Congressional authorization for the expansion of Head Start services to pregnant families and children under age 3 and their families provided another important opportunity to build capacity in the infant–family field through the development of a regional and national training and technical assistance system for Early Head Start (EHS) programs and their community partners. The national Head Start Performance Standards were instrumental in establishing the parameters for EHS services and, thus, for the training of EHS. EHS funds provide on-site program consultation, regional and national meetings devoted to cutting-edge research and practice, and print and video materials on issues of special concern to EHS staff. Two special initiatives, the first focused on better serving very young children with disabilities and the second on infant mental health, involved small program teams including parents in an intensive, interactive training experience followed by at least a year of on-site training and technical assistance by mentors and consultants. Both initiatives also had the resources to engage outside evaluators to study the process of change at the individual program level and across sites.

Growing ZERO TO THREE

ZERO TO THREE was born in 1977 and "grew up" during the period briefly described above. From its inception, ZERO TO THREE assumed a multidisciplinary perspective and focused on building and disseminating cross-cutting knowledge and skills throughout the infant–family workforce. Its first National Training Institute (NTI) brought together researchers, teachers, and clinicians from a number of disciplines to discuss what they were learning about early development and to identify the knowledge gaps in the field. Assessment, diagnosis, and treatment of physical and mental health problems in infants and toddlers were identified as key issues at this meeting. The result was a surge of new ideas and materials for practitioners working with children under age 3. The *Zero to Three Bulletin* was launched in 1980. Each issue focused on a single topic, with articles written from a variety of perspectives by practitioners across the field.

In the late 1980s, ZERO TO THREE launched its Training Approaches for Skills and Knowledge (TASK) project. Guided by a multidisciplinary task force, the TASK Project identified four elements of training important for all practitioners as they moved from preservice preparation to their first and subsequent jobs in the infant–family field:

1. A knowledge base built on a framework of seven core concepts common to all disciplines concerned with infants, toddlers, and their families;
2. Opportunities for direct observation and interaction with a variety of children under age 3 years and their families;
3. Individualized supervision that allows reflection on all aspects of work with infants, families, and colleagues; and
4. Collegial support, within and across disciplines, that begins early in training and continues throughout the practitioner's professional life.

This conceptualization reflected a belief in the importance of professional experiences not typically thought of as "training" and indicated that many qualitatively different kinds of experiences over a professional's lifetime are

necessary to build and maintain competence in a workforce as diverse as that serving babies and families. Practitioners need to acquire the knowledge and skills of their own discipline and also learn to adapt them to the specific requirements of work with infants and toddlers and collaboration with their families. Infant–family practitioners need support in their often-isolated work with babies and need the opportunity to process their experiences with others. These training elements—support and reflection—taken together underscored the belief that individuals with many different levels and types of training, experience, and personal qualities can become competent if they are given appropriate roles and supported in their work. Programs can become competent overall if they provide such support and guidance to staff.

The beliefs, values, and prior experiences that an infant–family practitioner brings to a professional development experience give it meaning and determine, to a large extent, what will be incorporated and used.

Key concepts in the TASK knowledge base (e.g., the significance of endowment, maturation, and individual differences in the first 3 years; the power of human relationships for affecting development; the interrelationship of developmental processes; risk, coping, adaptation, and mastery as key organizers of development) were intended to serve as a common language across disciplines concerned with infants and toddlers. They were crafted to be broad and flexible to allow for integration and adaptation of new findings from research and clinical practice on an ongoing basis.

ZERO TO THREE then undertook a deeper exploration of individual supervision as an untapped resource for infant–family practitioners attempting to solidify their knowledge and skills, examine their interactions with families, and explore their feelings and reactions to their work. ZERO TO THREE again convened a national multidisciplinary work group to study supervision as a relationship for learning. This initiative brought together the varying perspectives of students, teachers, front-line practitioners, supervisors, mentors, and administrators to advance the field's thinking about how supervision could be used to promote learning, collaboration, and reflection in individual practitioners and in infant–family programs as a whole. Talented individuals and groups across the country worked alongside ZERO TO THREE to build and publish a body of work that expanded our understanding of the nature of the supervisory relationship, the role of supervision in improving practice, and incremental steps and approaches to incorporating supervision in a variety of infant–family service settings.

Over the years, ZERO TO THREE continued to create training approaches and materials built directly on the work undertaken in the TASK project. The concepts and principles that guide us, and that guide many others in the field, center on the potential of the multiple relationships surrounding the baby to support his or her development. When practitioners take the time to reflect on these relationships in their work, to become aware of the influences that shape their own views, and to understand the individual needs of those with whom they interact, the learning that takes place can add immeasurably to their success in building strong and effective relationships on behalf of babies. How a practitioner *is* is as important as what a practitioner *does* with the infants, toddlers, and families he or she interacts with each day. The beliefs, values, and prior experiences an infant–family practitioner brings to a professional development experience give it meaning and determine, to a large extent, what will be incorporated and used. Such values and beliefs, at both the program and individual levels, must be recognized and reflected on as the critical context within which all training takes place.

ZERO TO THREE and others have worked to help program directors, management staff, and consultants adapt these ideas as they work to build relationship-based organizations and promote reflective practice in their work environments. The recognition of parallel process, that each relationship that surrounds the child affects the other relationships that surround the child, can serve as an impetus to create safe, intellectually stimulating, and reflective environments within which infant–family practitioners can deliver services.

Building and Disseminating the Infant–Toddler Knowledge Base

The 2000 publication of *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Shonkoff & Phillips, 2000) provided the field with a synthesis of the knowledge developed over the last quarter-century. The explosion of neurobiological, behavioral, and social science research helps explain the conditions that influence development. The multidisciplinary committee that authored *From Neurons to Neighborhoods* formulated three key developmental tasks of early childhood: negotiating the transition from external to self-regulation, including learning to regulate one's emotions, behavior, and attention; acquiring the capabilities that sustain communication and learning; and learning to relate well to other children and form friendships. The committee proposed 10 core concepts to help provide a framework for understanding human development during the earliest years, many of them quite similar to those proposed in the earlier TASK work. The delineation of key developmental tasks and core concepts can, and certainly will, provide the basis for training infant–family practitioners for many years to come.

From Neurons to Neighborhoods reminds us that child welfare and mental health practitioners must both learn

and be concerned about the quality of the parent–child relationship and the steps that need to be taken when relationships are disrupted. Childcare providers and early interventionists must figure out what their common goals are and continue to find ways to exchange their knowledge and build common practices that allow children with disabilities to flourish in group care. EHS programs can usefully incorporate mental health principles into their work with highly vulnerable children and families and with pregnant women. Pediatricians and developmental specialists can bring their diverse training and perspective to bear on the same children in a health care practice and, thereby, provide enhanced care.

Dissemination of this knowledge will involve formal and informal strategies that the field has used for many years. Higher-education programs across the country that offer degrees, specializations, or fellowships focused on some aspect of infant–toddler development will continue to incorporate new research and clinical knowledge. College and university faculty who teach courses at the 2-year, 4-year, and graduate levels that include infancy to some degree will continue to have a challenging job as they try to imbed sufficient content about, and direct experiences with, infants, toddlers, and families into the already-crowded early-childhood curriculum. We know for certain that higher-education continues to experience a significant challenge in producing adequate numbers of trained infant–family practitioners.

In-service training and continuing education continue to be the sources for training most relevant to a practitioner's particular job. Practitioners typically participate in a multitude of training venues including half-day workshops on a single topic, several-day conferences on a variety of issues, intensive summer institutes to meet the needs of a particular discipline for in-depth knowledge about a specific aspect of care, multidisciplinary meetings that focus on a particular pressing concern in the field, brown bag lunch groups, long-term study groups, and on-line continuing education offerings. But in-service training is typically spotty, uncoordinated, unsequenced, and often non-credit bearing. The infant–family field has a long way to go to make training available and accessible for staff at all levels—from entry level to master practitioner. To provide genuine career mobility, the knowledge and skill gained from experience must be acknowledged and documented through an authoritative body. This is particularly important in the childcare and education arena, in which research has documented the importance of training and education, both general and child-related, to the quality of care provided both in centers and in family childcare homes. Although the field continues to respond in sustained and creative ways, we have a long way to go in both the preservice and in-service arenas to produce the numbers of trained practitioners the field needs.

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What We Have Learned and Thoughts for the Journey Ahead

Each person who directly or indirectly provides services to infants, toddlers, and families deserves training and support. That includes program directors, management staff, supervisors, front-line staff, and all others whose work contributes to the quality of services. Just as we approach each infant and toddler as unique and whole, our training and professional development activities should think of the adults who serve them in the same way. All individuals working with babies and toddlers, regardless of what they bring to a particular job, need a professional development plan that identifies their strengths, helps them build a connection between personal experience and work, helps them identify the knowledge and skills they want to master, and assists them in developing essential skills in self-awareness and reflection. All individuals working with babies and toddlers deserve a work environment that values and supports their curiosity, their attempts to understand the meaning of behavior, their efforts to observe closely and to try new things, and their striving to be a more responsive partner to the children in their care and to the parents of these children.

The training and support we provide must be built on what we know about how and why adults learn and change. We should try to find out what they want to know, what they believe would be valuable. Experiences must be matched as closely as possible to the needs of audiences that often represent a wide range of disciplines, work experiences, cultures, values, beliefs, and learning styles. To be truly effective, a trainer must build a partnership—a relationship—with the learner, and learning experiences must engage the emotions as well as the intellect, just as work with children and families does. The field needs trainers who are skilled at integrating what we know about early

child development with experiences that help learners reflect on their own feelings, biases, and beliefs about child-rearing and parenting. Training at every level must model the connection between our intellectual and emotional sides, touch our need to laugh and reach out to others, and help us use our knowledge of the infancy field and our self-understanding to increasingly learn to do the right things, at the right time, for the right reasons. This enables practitioners to build and retain the capacity for a fresh and energetic response every time they encounter a baby and family and to respond appropriately to the needs of those who are most vulnerable.

The changing racial and ethnic make-up of the country and of the children and families served in programs calls for us to dramatically step up our efforts to build a representative infant–family workforce. Immediate and sustained attention must be directed to recruiting, training, and supporting people of color at all program levels, in all settings, and in all disciplines. The field will change and mature as a result of a more diverse workforce, and children and families will benefit.

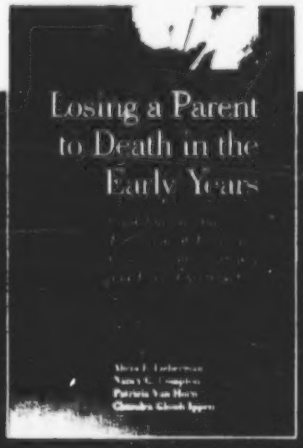
Leaders in all aspects of the infant–family field need ongoing personal and professional experiences that enable them to remain dedicated to the task of promoting healthy development in all infants, toddlers, and families. They will benefit from exposure to new knowledge that will enable their staff to do their best work. They need to learn to effectively evaluate their services and the effect they are having on children and families and to develop creative and realistic plans for continuous improvement. They need help in creating work environments that promote good services, commitment, and passion for the work. In the face of tremendous demands to do more with less, current and rising leaders in the field deserve our best efforts in professional development and support.

We as a field will stretch ourselves to build on what we know to be of value as we continue to train, motivate, and support the infant–family workforce. Babies and families, and those who serve them, deserve nothing less.

REFERENCES

Shonkoff, J. P., & Phillips, D. A. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

When the Parent of a Young Child Dies, What Can You Do to Help?



Losing a Parent to Death in the Early Years: Guidelines for the Treatment of Traumatic Bereavement in Infancy and Early Childhood

Alicia F. Lieberman, Nancy C. Compton, Patricia Van Horn, and Chandra Ghosh Ippen

Alicia Lieberman, Nancy Compton, Patricia Van Horn, and Chandra Ghosh Ippen have worked for many years with bereaved young children and their families at The Child Trauma Research Project in San Francisco. They share their hard-won knowledge in this new book from the ZERO TO THREE Press.

When the parent of a young child dies, the child's world can never be the same. Babies and toddlers depend almost completely on their parents for their sense of security. A child who loses a parent to death in the earliest years of life loses the person who provided the continuity and predictability that are the foundations of physical and mental well-being.

With sufficient knowledge, institutional support, and emotional availability, mental health clinicians can perform an enormous service to bereaved infants, toddlers, and preschoolers, and to their families. *Losing a Parent to Death in the Early Years* offers clinicians, counselors, educators, child-care professionals and others a compassionate yet practical guide to the assessment and treatment of infants, toddlers, and preschoolers who have experienced the death of a parent or primary caregiver. The authors describe how babies and very young children typically respond to overwhelming loss, explain complications in the grieving process that are associated with the sudden or violent death of a parent, and offer vignettes that illustrate therapeutic interventions with traumatically bereaved young children and their families.

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A View of Early Childhood Development

Irving B. Harris
Irving B. Harris Foundation, Chicago
Excerpted from four oral interviews with Richard Polsky

People often ask me, "Why are you, a businessman, concerned about child development and about the cycle of poverty?" (Sub-question: "What are you, some kind of a freak?")

It's a perfectly good question. Twenty-five years ago, when I talked to people about early childhood development, they assumed that I "loved children." I finally told about the hundredth person who asked me the question, "I think I love children about the same as anyone else does. But I don't have a *particular* love of children." Actually, I became interested in early childhood development through my interest in school failure.

When I started to express my very deep concern about early childhood development more than 20 years ago, I didn't cause any conflict. No one said to me, "You're crazy; you shouldn't be doing that; it's bad." Most people took little notice. They may have thought I was a little off my rocker, but I wasn't hurting anyone. In the last 25 years there has been a tremendous evolution. Today, an idea that was so strange to most people that they didn't care about it has actually become conventional wisdom: Many people say we really ought to do much more about early childhood development.

at a glance

- If you're going to have strong hunches, it's a good idea to have a hunch that's right.
- Get to know people who are very knowledgeable. A businessman who knows nothing about a problem ought to keep his mouth shut.
- With good thinking and good public relations, you really can get a huge impact, but we've never been able to do it in the early childhood field.

However, most people still have come only as far as Lyndon Johnson when he began Head Start. They have reached the same plateau that he was on, thinking that we ought to have more "preschool" education for 3- and 4-year-olds. They don't realize that Head Start is too late. I don't think that there are more than maybe 1 or 2% of people that really believe you have to start from birth with a child. Maybe 1 person in 100 today believes that children are ready to learn at birth. Voices for Illinois Children gets $1 million a year from the McCormick Trust, and they spend it on advertising saying that learning starts at birth.

I am no longer looked upon as a crank. I'm looked upon by some now as a seer — someone who really saw this in advance. I must say that I had a strong hunch that very early childhood was important to every individual's eventual development as a successful student, employee, and citizen. I would say that if you're going to have strong hunches, it's a good idea to have a hunch that's right. I don't claim that all of my hunches are always good — but this one has been superb.

Making Change as a Grant Maker

I have carried over from business a "venture capitalist" way of thinking about new philanthropic "ventures." The Irving B. Harris Foundation has started new initiatives, always in partnership with the community and using available leadership from the field. When contemplating a potential investment, I consider:

1. What are the odds of success or failure?
    a. If it fails, how much will be lost?
    b. If it succeeds, what will be the value of the gain?
2. Does the potential gain multiplied by the odds for success outweigh the potential loss?

Very often, the risk of failure, let's say, is 50/50; the failure will cost $50,000. If you are right — suppose you would gain $10 million. It certainly is worthwhile taking the chance.

You can't do the work without getting to know people who are very knowledgeable. I am regarded by a lot of people in the field as knowing more than most early childhood professionals. Why? There's a reason for it. In this era of specialization, it's very strange how limited to specific periods (of development) most professionals are. They seize on one category and exclude knowledge or perception about what seems to them peripheral categories. The sociologist William Julius Wilson and I were on some sort of committee together, and he was absolutely stunned by what I knew about early childhood development stuff that he didn't know. But it's something that interests me, and I know a lot of people in the field. I read, and I put little things together. I don't mind saying what I think. I don't hesitate; I've got nothing to lose. I don't have a job that's at risk.

ANDRES GUERRERO

Doulas: A New Way of Reaching Young Mothers

Our failure to make progress in maternal and child health in the United States reflects our reliance on the medical model of health promotion. It's vital we understand the role of culture and community in childbearing and childrearing decisions among low-income women and women of color. To be successful, we must develop new strategies and models for culturally approved maternal and child health promotion. Most women, even those who do not receive adequate prenatal care, know that prenatal care is important to healthy pregnancy outcomes. Most women, even those who are used to hostile treatment from health institutions, know that some women have better birth experiences than others. Most women, even those who bottle-feed, know that breast-feeding is better for an infant's health. Simply knowing these facts, however, does not seem enough to persuade a mother to get regular prenatal care, make informed birth choices, and choose to breast-feed. We must acknowledge that there is another level of crucial information of support affecting women's health choices. We need to understand the limitations of health professionals' roles in addressing sociocultural factors that affect the very personal decisions made by lower-income and minority women. It's clear that the barriers to successful obstetrical and birth outcomes and to breast-feeding that are associated with social class and culture are enormously powerful forces.

The wonderful thing about the doula program is it seems to reach the young mother when she's most able to hear and wants to learn about what their labor is going to be, how

difficult it's going to be, how long it's going to last (see *Zero to Three*, 21(2) and 23(2)). Because our doulas have themselves been mothers, they are a natural resource for the girls who meet them early on to ask them about what labor is going to be like. And it gives the doula an opportunity to talk to the young mom. Many of these mothers would normally have (beliefs about how to bring up a baby that would result later) in neglectful caregiving. But the doulas were able to tell these moms that the birth will be a God-given, wonderful opportunity. "A baby begins to learn right at birth. You're going to have this wonderful baby who is going to look to you and you can really have an enormous impact on his baby." And they would talk to the moms several times and the consequence was that about 80% of these moms breast-fed. Before we came along, maybe 1% of the African-American girls breast-fed.

There seems to be uniform acceptance of the doula program. Nobody thinks it's a bad idea, and a large number of people now are beginning to say that it is really accomplishing something. I've heard new doulas say to us, "I never in all my life thought I'd ever have a job like this, the opportunity to really make a difference. It's wonderful!"

Training the Infant–Family Work Force

In 1966, a year after Head Start began, I provided sole funding for the first 2 years of Erikson Institute, which was founded to train Head Start teachers in Chicago. I continue to support Erikson, which is now 37 years old. Its Infant Studies Program will celebrate its 20th anniversary in 2004.

In the mid 1970s, my support for Erikson led to an invitation from Dr. Reginald Lourie of the National Institute of Mental Health to join the Board of the newly organized National Center for Clinical Infant Programs (now ZERO TO THREE). I've learned a great deal from my fellow Board members.

It seemed to me that if early childhood development was as important as we were saying it was, we needed to train more people for the work. I asked some of the people I knew who had training programs (both on and beyond the ZERO TO THREE Board) what they could do to improve infancy training — differently or additionally — if they had more money over a period of 5 years. Based on their answers, I have now funded the expansion of a dozen infancy training programs in the US and a consortium of three programs in Israel. We have no formula for how training should be done. We encourage the programs to meet periodically to compare notes.

Public Policy and Early Childhood Development

I gave a speech to students of public policy in May 1994, called "Should Public Policy Be Concerned With Early Childhood Development?" At the beginning of the speech, I said:

> *To most people, babies and early childhood development are of minor interest in the total scheme of things. And the program of contraception and availability of abortion for poor women is seen, by most people, as a specialized kind of problem of interest to only a few reproductive rights radicals. Almost never are the $450 billion we spend annually on education in this country for children and youth aged 5 to 25, or the economic and social costs of crime, violence, and prisons, and the huge costs, both economic and social, of our welfare system ever considered as closely related to public policies about babies and contraception and abortion. I believe they are closely related.*

I think this theme is important. But how can I get it on the public agenda? It's not easy.

I have a very modest opinion of my capacity to change people. I believe that when people vote in an election, I think their minds have really been shaped by a whole variety of factors, the least important of which is political speeches they have heard or read about in the previous 2 or 3 months. Ninety to 95% of the time their political convictions have been shaped by events that occurred long before the current campaign. Their fathers, their mothers, their brothers, their sisters, whatever the factors were, those all unconsciously fixed how they are going to vote and how they are going to perceive what the candidates say.

I know from my experience with Toni Home Permanent what good public relations can do. With good thinking and good public relations, you really can get a huge impact. We've never been able to do it in the early childhood field. I know how it's done, but I've never been able to do it.

Another thing — businessmen, if they've been more or less successful, are given an undue amount of credit for probably knowing what they are talking about. That's one of the great myths. A businessman who knows nothing about a problem ought to keep his mouth shut.

THE IDEA BEHIND IDEA:

Creating, Shaping, and Refining Early Intervention Legislation

CAROL BERMAN *and* **CINDY OSER**
ZERO TO THREE, Washington, DC

ADDISON SALE

Creating, shaping, and refining legislation to provide early intervention services for infants and toddlers with disabilities and their families is an undertaking that began decades ago and that must continue indefinitely. Consequently, there is no way to acknowledge adequately the contributions of even a small fraction of the individuals and organizations that have significantly influenced early intervention policy. Nevertheless, we honor the people listed here for both the substance of their thinking and the selflessness of their concern for infants and toddlers with disabilities and their families. Too many of these colleagues are no longer with us. Those of us who remain—and the new generation of parents, professionals, and policymakers—will continue their work, inspired by their example.

We thank Joe Ballard, Kathryn Barnard, Julianne Beckett, Tom Behrens, Tal Black, Jim Blackman, Pip Campbell, Camille Cook, Athleen Coyner, Joan Danaher, Jane DeWeerd, Mary Elder, S. Gray Garwood, Linda Gilkerson, Jim Hamilton, Barbara Hanft, Gloria Harbin, Al Healy, Ed Hinckley, Vince Hutchins, Jean Johnson, Karl Kastorf, Phyllis Magrab, Merle McPherson, Sam Meisels, Duncan Munn, Kathy Peppe, Peggy Pizzo, Patti Place, Sally Provence, John Schwab, Jack Shonkoff, Bobby Silverstein, Barbara Smith, Eleanor Szanton, Pascal Trohanis, Liz Vincent, Sharon Walsh, Fred Weintraub, Pat Williams, Gordon Williamson, Shirley Zeitlin, and Martha Ziegler.

On October 8, 1986, amendments to the Education of the Handicapped Act (P.L. 99-457, later renamed the Individuals with Disability Education Act, or IDEA) were signed into law. The act created a new discretionary program to help states plan, develop, and implement a comprehensive, coordinated set of services for infants and toddlers with disabilities and their families. ZERO TO THREE immediately encouraged parents, practitioners, researchers, and administrators to

at a glance

- Beginning in 1986, P.L. 99-457 (later re-named IDEA) provided states with new opportunities to serve children from birth through age 2 with disabilities and their families.
- ZERO TO THREE's evolving role in the creation, shaping, and refining of IDEA illustrates the process of building capacity to serve as a resource to federal and state policymakers and to child and family advocates.
- Strong collaborative relationships with concerned parents and with Congressional staffers are powerful engines for policy change.

comment on the federal regulations that would govern implementation of the new law and to become actively involved in their states' decision-making.

Three years later, ZERO TO THREE published ***The Intent and Spirit*** *of P.L. 99-457: A Sourcebook* (Project Zero to Three, 1989), which included the House Committee on Education and Labor's full report on the rationale for and intent of the infant–toddler provisions of the Education of the Handicapped Act of 1986. The booklet included excerpts from a speech by Robert (Bobby) Silverstein, counsel to the House Subcommittee on Select Education from 1985 to 1987, entitled "A Window of Opportunity." Indeed, P.L. 99-457 did provide new opportunities to serve children from birth through age 2 with disabilities and their families. States took the offers for funding, some of which resulted in benefits for infants and toddlers and some of which proved a disappointment.

A look at ZERO TO THREE's role in the development and implementation of the infant and toddler provisions of IDEA during the past 2 decades—from the 3 years before the enactment of P.L. 99-457 until the present—reveals a great deal about the process of collaborative policy development on behalf of infants, toddlers, and their families. Such a review also illustrates how ZERO TO THREE has built its capacity to serve as a resource to federal and state policymakers and also to advocates for very young children. This article describes both the early work of crafting a vision of comprehensive services for infants and toddlers with disabilities and the process of building strong alliances with the leaders who shaped this service system through legislation, funding, regulation, and implementation. We recall the events that led to passage of P.L. 99-457, Part H (later Part C of the IDEA) and the history of the law since 1986. We conclude with observations on the continuing journey of Part C and current pressing issues in early intervention.

Crafting a Vision: There Ought To Be a Law?

In 1983, the Maternal and Child Health Bureau (MCHB) awarded a grant to ZERO TO THREE (then called the National Center for Clinical Infant Programs; NCCIP) to work with 10 states that were trying to improve services for infants and toddlers with special needs. These states were using an approach that seemed quite novel 20 years ago—creating interagency committees to develop coordinated systems of care. We called our initiative "Project Zero to Three" and convened teams from the 10 participating states so that we could learn from each other. Each state's project team included the director of the state's Maternal and Child Health agency; leaders from one or more related agencies, usually Special Education and Mental Health; one local service provider; and at least one parent. In 2-day meetings, the teams talked about issues such as systems for early identification and monitoring of babies with or at risk for disabilities; personnel training; continuity of care for high-risk infants; and the quality of services for infants and toddlers with special needs and their families. Parents of young children with disabilities played a prominent role in Project Zero to Three from the beginning. Today it is commonplace for parents to work in equal partnership with professionals, but it was a novel concept in 1983.

In one project meeting, Barbara Smith, who had worked with the Division of Early Childhood, Council for Exceptional Children (DEC/CEC), helped us imagine the consequences if federal or state legislation were to create a system of services for babies with special needs. From Barbara's lucid analysis and project discussions came the publication *There Ought To Be a Law?* (NCCIP, 1984). The publication reviewed policy options (e.g., legislative action, executive action, and interagency agreements), critical choices (e.g., the definition of the population to be served), and incentives for stakeholders to delineate and strive for best practices.

In 1984, MCHB, in collaboration with the Office of Special Education and Rehabilitative Services, asked ZERO TO THREE to host a conference on "Comprehensive Approaches to Disabled and At-Risk Infants, Toddlers, and Their Families." Every plenary session included a parent speaker. The best known was Julianne Beckett, who had needed to go all the way to Vice President George Bush to

obtain a waiver from existing Medicaid policy, which would not pay for the ventilator and nursing care that would allow her daughter Katie to live at home. Today the so-called "Katie Beckett waiver" now permits Medicaid and other third-party payments for in-home care for children who would otherwise require residential medical care.

In 1985, with continuing support from MCHB, we added 5 states to our Project Zero to Three network. With the help of the project's advisory committee, we forged partnerships with the American Academy of Pediatrics, DEC/CEC, and other organizations. Because ZERO TO THREE staff could not work on legislative issues as part of a federally funded project, Carol Berman joined the DEC/CEC Government Affairs Committee and became an active committee member, working evenings and on weekends.

Our role in the ZERO TO THREE Policy Center is to develop relationships with Congressional staffers and provide timely, accurate information to them on infant-toddler issues.

Taking the Vision Seriously: Federal Legislation Takes Shape

In 1986, the Education for All Handicapped Children Act (P.L. 94-142) was being reauthorized. One Saturday morning early in 1986, Berman and other DEC/CEC Government Affairs Committee members learned that Senator Lowell Weicker (R-CT) was proposing to amend the Act and that there might be an opportunity to make changes in the law for infants, toddlers, and young children. The existing law provided discretionary funds for demonstration projects serving children young children with disabilities. Most of the funded projects focused on children ages 3 to 5 years, but some included infants. The demonstration projects were showing that services for preschoolers with disabilities were helpful, and enthusiasm for Project Zero to Three among administrators, practitioners, and families suggested that the time had come for an infant–toddler program.

Several weeks later, Berman arranged a meeting with Representative Pat Williams (D-MT), chair of the House Subcommittee on Select Education of the Committee on Education and Labor, to discuss the possibility of an infant–toddler component in the new law. One question that Williams asked was "Do we know how to test infants to find out if they have disabilities?" It seemed a simple question at the time. We told him about statewide tracking systems and provided copies of the publications that came from Project Zero to Three. Among these were *Warning Signals: Basic Criteria for Tracking At-Risk Infants and Toddlers* (Blackman, 1986), *Equals in This Partnership: Parents of Disabled and At-Risk Infants and Toddlers Speak to Professionals* (NCCIP, 1985), and *Infants Can't Wait: The Numbers* (NCCIP, 1986). (It would take us another 27 years to issue a data book, *America's Babies: The ZERO TO THREE Policy Center Data Book*, by C. Oser and J. Cohen, which will be released in October 2003.) The meeting with Williams and his staff led to invitations to provide additional information and testimony for the Subcommittee on Select Education and to meet with other members of Congress and their staff.

At this point we learned a lesson that they don't teach in 8th-grade civics in the unit on how a bill becomes a law—the role of congressional staff members in shaping legislation. Each representative and senator has a staff. Each House and Senate committee—and the subcommittees of the committees—also has a staff. Through research, meeting with advocates, and coordinating hearings, many subcommittee and committee staff members acquire a depth of knowledge that gives them a great deal of influence with senators and representatives, who may have spent less time in the Capitol than their staffers and who can seldom spend the time required to master all of the details of legislative proposals. Our role in the ZERO TO THREE Policy Center is to develop relationships with staffers and provide timely, accurate information to them on infant–toddler issues. We want them to rely on us as key informants.

In the House of Representatives, amendments to the Education of the Handicapped Act were under the jurisdiction of the Subcommittee on Select Education of the Committee on Education and Labor, chaired by Pat Williams. Bobby Silverstein was counsel to the subcommittee, and S. Gray Garwood was staff director. Berman, Project Zero to Three liaisons and advisors, and members of ZERO TO THREE's Board of Directors made themselves available to Silverstein, Garwood, and others as House and Senate versions of the amendments were drafted, moved through subcommittees and committees, voted on, and shaped into a single piece of legislation in the conference committee. In the process we learned that congressional staff members are knowledgeable but not omniscient. At one point Garwood told Berman, "There will be an expanded early intervention preschool program, but forget the infant-toddler piece. Senator Weicker's version doesn't have it, and it's not going to happen." As things turned out, the passage of a law that included a policy for early intervention for infants and toddlers with disabilities was one of Senator Weicker's final achievements before retiring.

We were confident that interagency committees in states across the country could work together and replicate what was happening in Project Zero to Three states. One concern was the extent to which state education agencies—which might acquire lead responsibility for implementation of a new law—were seriously interested in infants and toddlers. In Project Zero to Three, some of the stronger programs were

based in health departments and mental health agencies. We worried that education agencies would be less likely to interact with parents of infants with or at risk for disability at the earliest points of contact—that is, in hospitals immediately after birth, during home visits by public health nurses, and in physicians' offices during well-baby visits. We also worried that education agency-based programs might be strictly child focused; after all, children usually arrived in school programs without their parents. To ensure the earliest identification of babies with disabilities or high-risk conditions, a state lead agency in public health or a solidly connected interagency team seemed most desirable.

Mapping the Future: Early Implementation of P.L. 99-457

P.L. 99-457 was signed into law in October 1986. For the infant–toddler program (Part H), the law provided $50 million in federal funds and a 5-year period during which states could gear up for Part H programs. To receive funds, states would have to designate a lead agency (not necessarily the state education agency) and establish a state interagency coordinating council. The law provided no entitlement to services for eligible children. However, participating states would need to respond to the system requirements, including creating a definition of developmental delay, designing public awareness and early identification systems, and spelling out the state's plan for evaluating and serving infants and toddlers with disabilities. In addition, states had to craft policies for personnel standards, financing, interagency agreements, and data collection, among other areas. P.L. 99-457's mandate for collaboration among multiple agencies, providers, and parents was a tall order for states, but all 50 states opted into the 5-year planning phase.

States hired Part H coordinators, who experienced varying degrees of success and frustration. Soon, there were as many Part H systems in place as there were states. Certain questions were common across states, no matter which agency was in the lead:

- Who were the "at-risk" children?
- What would be the benefits of including them in the population to be served by Part H?
- What would be the adverse consequences?
- What were the entitlements of children who met the definition of "disabled?" Of "developmentally delayed?"
- How should developmental delay be determined?
- What kind of personnel system was needed?

Every state struggled to define and organize its Part H system. As this was happening, C. Everett Koop, the U.S. Surgeon General, was promoting the concept of "family-centered, community-based, coordinated care." This national effort helped support and extend the interagency planning efforts started by Project Zero to Three and now required by P.L. 99-457, Part H. Not surprisingly, the 15 state teams participating in Project Zero to Three surfaced as role models for lead agencies. A network of researchers, demonstration

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programs, technical assistance centers, and consultants quickly formed. ZERO TO THREE entered into a contract with the University of North Carolina at Chapel Hill and other partners to provide technical assistance to states through the National Early Childhood Technical Assistance System (NEC*TAS). It was an exciting time.

In 1990, P.L. 99-457 was reauthorized as IDEA. The legislation's new name adopted the preferred practice of "putting people first" (i.e., individuals with disabilities). Similarly, the term *service coordination* replaced *case management*. And in the Senate itself, the Subcommittee on the Handicapped became the Subcommittee on Disability Policy. A question that generated a great deal of discussion during the reauthorization process concerned federal funding for provision of services. Originally, Part H funding was characterized as "glue money," on the theory that if all programs and funding streams for young children with disabilities were coordinated, and unnecessary duplication was eliminated or reduced, Part H funds could be the system's "glue" (i.e., used for systemic efforts such as public awareness, training, and family involvement) and used only as the payer of last resort for direct services. As Part H progressed, however, it become obvious that coordination alone would not free enough funds to serve all the infants and toddlers who could benefit from early intervention. States were increasingly using Part H glue money for services.

Eventually, as eligible children's entitlement to Part H services increased costs, states began to tighten their definition of developmental delay. We and our colleagues in NEC*TAS watched as increasing numbers of states excluded from eligibility children at risk for disability. Our dream for Part H was a comprehensive, coordinated system in which all agencies serving infants and toddlers with disabilities would

provide services collaboratively and share in the costs of doing so. But, by the time most states had passed the 5-year "planning phase" and entered full implementation, Part H was clearly becoming a categorical program for young children with disabilities. Moreover, Part H was competing with other categorical programs for funds, pitting children with disabilities against adults with disabilities, children who are poor, children in foster care, and even children in specific disability categories. Today multiple advisory and coordinating councils exist at the local, state, and federal levels. New committees continue to be created. In most places, it is the same people who gather no matter what the board, council, or committee is called. The members must be reminded what "hat" they are wearing at any given meeting.

Charting Change: New Windows of Opportunity

In January 2002, ZERO TO THREE launched its Policy Center and chose Part C early intervention as a priority policy focus. The timing was perfect; IDEA was once again up for reauthorization in the108th Congress. Although the science of early childhood intervention was getting attention in the media and in the policy world, the federal and state context for policy change was dismal. States were facing the worst economic situation since World War II. Some governors were threatening to pull out of the federal Part C program. Yet Part C referrals continued to increase, and some states had waiting lists of 3 months or more. Families were feeling that they could not afford either the time or the resources to get all the services that were being recommended in Part C evaluations. Although some federal programs that serve infants and toddlers with disabilities, like Early Head Start, are growing and provide an excellent option for some families, there were simply not enough of these programs to accommodate all who wanted or needed to enroll. It is estimated that as many as 4% of all infants and toddlers in the United States have disabilities. But, in 2001, only 2.13% (246,988 children) were served in Part C nationwide (U.S. Department of Education, Office of Special Education Programs, 2003).

One of the first tasks of the ZERO TO THREE Policy Center was to draft a policy statement on Part C reauthorization, based on the recommendations in *From Neurons to Neighborhoods: The Science of Early Childhood Development*, a 2000 report by the National Academy of Sciences Committee chaired by current and former ZERO TO THREE Board members Jack Shonkoff and Deborah Phillips. Instead of basing our recommendations on practical state experience alone, we now made policy recommendations based on research findings. When it came time to reauthorize Part C, we looked to science to suggest improvements in the program. The science of early childhood intervention tells us that the early years are foundational for later development, that school readiness begins long before the ABCs, and that early intervention can have significant effects on young children with

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or at risk for disabilities. We know that early intervention can serve as a buffer against multiple risk conditions in children and families and that, without intervention, skills in children with disabilities decline.

After 17 years, the 2003 reauthorization of IDEA provided an opportunity to close the gap between what we *know* and what we *do* for infants and toddlers with or at risk for disabilities. In the policy brief *Improving Part C Early Intervention: Using What We Know About Infants and Toddlers with Disabilities to Reauthorize Part C of IDEA* (Oser & Cohen, 2003) prepared for congressional staff, state policymakers, and advocates, ZERO TO THREE offered the following recommendations to bring early intervention policy in line with current research findings:

1. Permanently reauthorize Part C.
2. Provide sufficient funding to identify and serve all infants and toddlers with developmental disabilities or delays.
3. Enhance early identification (child find) of infants and toddlers with disabilities.
    a. Require that every infant and toddler who is referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental–behavioral screening under Part C of the IDEA.
    b. Further strengthen linkages among Part C, Temporary Assistance for Needy Families, and early care and education systems.
    c. Expand the existing eligibility category of "diagnosed physical or mental conditions" to include "family conditions that have a high probability of resulting in a developmental delay, such as significant parental mental illness, parental substance abuse, and significant family violence."

4. Improve the overall quality of services through several mechanisms.
   a. Renew investments in professional development with a targeted focus on building expertise in early social–emotional development and mental health, including the creation of a National Resource Center for Infant Mental Health and Early Intervention.
   b. Develop and implement a set of standards for early intervention practice.

The ZERO TO THREE Policy Center uses a full range of electronic media for policy research and communication with advocates and decision-makers. Still, there is no substitute for personal encounters. Recently, we visited Capitol Hill with Kathryn Barnard, ZERO TO THREE Board member and professor of Nursing at the University of Washington. Staff from the Senate Health, Education, Labor and Pensions Committee and from Senator Patty Murray's (D-WA) office were captivated as Barnard told stories of parents challenged by prenatal stress and mental health issues and how infant mental health services could help these families. She also explained how a child who is not secure in relating to others, doesn't trust adults, and is not motivated to learn or calm enough to tune into teaching will not benefit from early educational experiences. In another visit, Jack Shonkoff, ZERO TO THREE Board member and dean of the Heller School for Social Policy and Management at Brandeis University, met with staff from Senator Ted Kennedy (D-MA) and Senator Lamar Alexander's (R-TN) offices, along with other early childhood special education advocates from Easter Seals, the Council for Exceptional Children Division for Early Childhood, the Part C Coordinators Association, and the National Association of Directors of State Special Education Programs. Shonkoff, as a leading expert in the science of early childhood development, stressed the research basis for extending eligibility for early intervention services to children who have been abused, neglected, or exposed to violence or whose parents' ability to parent has been disrupted by depression or other mental illness.

As of this writing, the reauthorization of IDEA is not yet final, but we have high hopes that some of our recommendations will make it into the Senate and House proposals for Part C. Some changes have been proposed that would remedy the concerns we have had. The Senate proposed a definition for developmental delay that would establish consistency among the states, even though it would not extend eligibility. States would no longer be free to establish their own definition. For some states, the proposal (eligibility based on 35% delay in one area of development or 25% or more in two or more areas) would mean a tightening of eligibility, while for others it would allow more children to participate in early intervention. Both the House and Senate proposals include ZERO TO THREE's recommendation requiring referral to Part C of infants and toddlers involved in substantiated cases of abuse or neglect. Enactment of this proposal will require states to reach out to new partners (if they haven't already been coordinating with child welfare and protective services); develop new interagency agreements around process and funding; and provide opportunities for early intervention staff, case workers, foster parents, and others to learn about the special circumstances of babies affected by abuse and neglect.

Developmental research supports offering early intervention to children who have been abused, neglected, or exposed to violence, or whose parents' caregiving has been impaired by mental illness.

Again, referral alone won't make these children eligible for Part C services, but it's a foot in the door and a step closer to the glue that Part C was intended to be. Adding children affected by family violence, parental mental illness, or substance abuse to the eligible population for Part C is also under discussion. States also may have a new option to extend Part C to age 5 and allow families the choice of staying with their Individualized Family Service Plan (IFSP) services or transitioning to free and appropriate public education through preschool special education.

The expansion of eligibility and the birth-to-5 extension of Part C are intriguing proposals, but without financial incentives, states are unlikely to choose to participate. Whatever the results of reauthorization, we predict that the early intervention field will look to ZERO TO THREE for guidance, training, and translation of what we know into what can be done better for babies and toddlers with disabilities and their families.

Conclusion

Beginning 25 years ago and continuing today, ZERO TO THREE has taken an active role in creating, shaping, and refining federal legislation for early intervention. In the early years, ZERO TO THREE had an advocacy role, speaking on behalf of babies and toddlers with disabilities and their families. We supported the translation of research into federal policy and state practice. We were communicators and conveners. We used the "honeybee" model of change, bringing states together, helping them share information and resources, "cross-pollinating" the system to infuse promising practices, and then moving this knowledge into the policy arena. Today, ZERO TO THREE has its own Policy Center, with staff knowledgeable and experienced in Part C. We have hired governmental relations consultants (yes, lobbyists) and are on Capitol Hill nearly every week, building relationships and working with other strong advocates—Easter Seals, DEC, the IDEA Infant Toddler

Coordinators Association, the Association for Maternal and Child Health Programs, the National Association of Directors of Special Education, the National Association for the Education of Young Children, and others. We produce fact sheets and policy briefs that have been quoted in federal hearings and used for state budget testimony. We are using sophisticated research-based approaches to change policy.

As strategic and planful as we are, the work is slow. To those of us who have been doing this work for many years, our accomplishments often feel like "baby steps" or even holding actions to fend off regression. But we are proud to build on the legacy of ZERO TO THREE's way of working. We build relationships—with policymakers, congressional staff, and other organizations. We listen—to practitioners, parents, researchers, and program leaders. We try to translate what we know into what public policy permits, encourages, mandates, and provides the resources to do.

REFERENCES

Blackman, J. (1986). *Warning signals: Basic criteria for tracking at-risk infants and toddlers*. Washington, DC: National Center for Clinical Infant Programs.

National Center for Clinical Infant Programs. (1984). *There ought to be a law? Ensuring statewide services for disabled and at-risk infants and toddlers*. Washington, DC: Author.

National Center for Clinical Infant Programs. (1985). *Equals in this partnership: Parents of disabled and at-risk infants and toddlers speak to professionals*. Washington, DC: Author.

National Center for Clinical Infant Programs. (1986). *Infants can't wait: The numbers*. Washington, DC: Author.

Oser, C., & Cohen, J. (2003). *Improving Part C early intervention: Using what we know about infants and toddlers with disabilities to reauthorize Part C of IDEA*. Washington, DC: ZERO TO THREE Policy Center. Available online at www.zerotothree.org/policy/policybriefs/PartC.pdf

Oser, C., & Cohen, J. (in press). *America's babies: The ZERO TO THREE Policy Center data book*. Washington, DC: ZERO TO THREE.

Project Zero to Three. (1989). *The intent and spirit of P.L. 99-457: A sourcebook*. Washington, DC: National Center for Clinical Infant Programs.

Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

U.S. Department of Education, Office of Special Education Programs (2003). Data tables for OSEP state reported data: Part C child count. Retrieved on September 5, 2003 from http://www.ideadata.org/tables25th/ar_ahc1.htm

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Cindy Oser and Julie Cohen

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"A citizen's movement of, as well as for, parents is the best route toward effective advocacy in the U.S. today."

—Theda Skocpol, Professor of Government and Sociology, Harvard University (1997)

Time and again it appears that policymakers know the difference between a constituency of service providers and one of parents. Legislators are known to become engrossed and listen attentively as a parent expresses what a proposed piece of legislation will mean to his or her life. Speaking from personal experience, parents poignantly relate stories that capture the hearts and minds of those responsible for shaping policies.

Recognition of the potential of a "parent voice" can be seen in the many efforts to reach parents and reflected in the multitude of terms used to describe their essential roles. Parent involvement and parent participation preceded terms indicating a more emphatic parent role, such as parent empowerment, parent leadership, and parent engagement. The phrase parent power is self-explanatory. The common element binding these terms is an awareness of the important place parents have in the institutions affecting their children's development. Whether it is involvement in a school setting or the leadership role in a community program, the voice of parents is heard—sometimes muted, sometimes loud and clear, but rarely is it discounted.

A look back supports the view that a growing interest in parents as active members of the child's world outside the home parallels the dramatic shift in thinking about human development in the 1960s—from a focus on the child alone to the child as part of a family whose role was primary in the child's development. Pediatrician and psy-

at a glance

- Parents organize around specific issues or immediate problems.
- Parent action grows from the bottom up—from community advocacy to national issues.
- Effective public policy promotes parent involvement.
- Good professional practice includes listening to parents and encouraging them to find their voice.

choanalyst D. W. Winnicott (1987) captured the essence of the caregiver–infant relationship when he reflected on his prior comment that there was no such thing as a baby, "meaning that if you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship" (pp. 4–5).

From diverse fields—early childhood, psychology, social work, family support, health—emerged a shared understanding of the child as part of an ecological system. Such an approach "assumes that family and child interaction, development, and functioning are embedded within broader aspects of the environment, which includes a community with cultural, ethical, racial, and socioeconomic characteristics" (Norton, 1994, p. 407). The concept of looking at the child as an entity separate from his parents was replaced by a desire to engage the family and community in efforts to create environments in which children could thrive.

A deeply embedded focus on individual self-interest is part of American culture. Many parents are ardent advocates for their own children but not for other people's children.

It is no wonder that several parent groups were initiated in the 1960s and 1970s, including those launched by parents of children with special needs and those with children in Head Start. This is not to say that social movements on behalf of families and children did not exist before that time. As far back as the 1800s, educators, reformers, and local citizen groups succeeded in establishing common public schools. In the early 20th century, responding to pressure from women's clubs across the country, the federal government and 40 states passed laws that funded mothers' pensions, enabling some poor widows to care for their children at home. The history of social policy landmarks for children reveals a "pattern of partnerships of government and popularly rooted voluntary associations," which was based on the "remarkable alliance of female professional advocates and grassroots women's federations" (Skocpol, 1997, p. 10).

Yet, over the years, tapping into the potential of the parental voice to affect national policy has been difficult. In the early 1990s, two efforts were launched to create a national "parent movement." Parent Action was founded in 1991 by a group of people prominent in early childhood and social policy for children. Its energetic and committed leadership organized successful events for parents in cities around the country, published a parent newsletter, and received heartwarming responses from parents. Yet few joined, and funding could not be obtained. At about the same time, in 1993, two prominent scholars founded the National Parenting Association. This organization's research documented the concerns of parents and the potential of parents as a voting bloc. Both of these pioneering efforts were launched from the national rather than the local level.

When we look across the United States, however, we see a new vitality emerging at the community level. Parents are banding together to address a variety of specific issues: They are speaking out for improved child care, reaching out to new fathers as part of the growing fatherhood movement, and working to ban junk food machines in their children's schools. Taken together, these newer efforts have the potential to make communities into places that promote the well-being of children and families.

The Challenges of Tapping Into the Potential of Parents

Before looking more closely at these emerging efforts, we need to consider some basic questions about parent advocacy. What characterizes long-standing parent groups? What barriers stand in the way of parents organizing? Thinking about these questions raises some issues inherent in the culture in which we live today. Ours is a society in which independence is highly valued and individual responsibility emphasized. A dominant assumption is that parents and parents alone "bear full responsibility for their children economically and in every other way" (Minow & Weissbourd, 1993, p. 11). For example, a working mother who is feeling frustrated because she cannot find, or afford, care for her 3-month-old baby blames herself for her inability to make better arrangements. She does not blame the social system that has failed to provide her with 6 months of paid parental leave or to ensure an adequate supply of good-quality, affordable child care for the infants of mothers who work outside the home.

Closely allied to this attitude is that of parents "who are ardent advocates for their own children but see no connection between this work and advocacy for other people's children" (Minow & Weissbourd, 1993, p. 14). An understanding of our interdependence and the relationship between one child's health to every other's is superseded in our culture by a deeply embedded focus on individual self-interest. A familiar African saying and concept, "It takes a village to raise a child," has not been embraced by large segments of the U.S. population. Rather, Americans are engaged in an ongoing debate on whether government should or shouldn't "interfere" with family matters.

When messages such as these permeate the culture, parents tend not to see the link between problems they face and family policies. Furthermore, parents do not think they have political power. Not only have demographic shifts reduced the number of voters that are parents, but since 1956, the turnout among parent voters has been poorer than among nonparents (Hewlett & West, 1998, p. 227).

Parental stress contributes to the difficulty in launching a national parent advocacy movement. Families' need for two incomes, plus the lack of community support for families and children, leads to the strains and tensions so often expressed in the phrase "I'm feeling so pressured." Parents say repeatedly, "I just don't have time for one more thing."

Even if time were available for parent action, community supports are not. There is usually no transportation for families to attend meetings, no arrangements for child care, and no translators when necessary for communication. Too often meetings are held during working hours.

Finally, parents are not a monolithic group. They may be conservative or liberal, religious or secular, working in or outside the home. Because parents have diverse viewpoints, finding common ground around which to organize has sometimes been difficult. Yet a 1993 study of parents showed that "parents care deeply about family values, which means sharing responsibility, caring for one another. They want vision and roots for their kids, and are worried about the decline in social contract" (Zimmerman, 1993, p. 4). A 1996 survey conducted by independent pollsters Penn and Schoen, under the aegis of National Parenting Association, revealed that one of the main issues for parents was "juggling work, community, and family responsibilities" and indicated a clear consensus among parents about a political agenda they would support (Hewlett & West, 1998, p. 215). Their chief concerns were safety and education; among their specific policy recommendations were easing financial burdens on parents, making the workplace more responsive to their child-related responsibilities, and improving safety through legislation requiring safety locks on guns. As widely divergent as their points of view are on many matters, parents agree on what is important where their children are concerned.

Parents in Action and the Lessons They Teach

Parents have often organized successfully around specific issues. Unmet need for good-quality, affordable child care, for example, has begun to stimulate parent action in a growing number of states and communities. In Boston, Parents United for Child Care was established more than a decade ago. Over the years, this pioneering organization has highlighted the need for after-school programs, helped parents tell their child-care stories, and worked to secure significant new resources for child care (Lombardi, 2003). A few years after the founding of Parents United, the Parent Voices Project was launched on the West Coast. A project of the California Child Care Resource and Referral Network, this parent-led grassroots organization works to make good-quality child care accessible and affordable to all families. In 2002, more than 300 parents attended "Stand for Children Day" in Sacramento, and Parent Voices held candlelight vigils, a press conference, and a meeting with the governor to win back millions in withheld child-care funding. Parent Voices chapters have emerged in several counties in California (Parent Voices, n.d).

The issue of school reform frequently motivates parents to advocacy. Perhaps one of the longest-standing of such efforts is the National PTA, which brings parents, educators, students, and other citizens together on behalf of improvements in schools and communities. The roots of the National PTA can be found in the first meeting of the National Congress of Mothers, held in Washington, DC, in 1897. In the early 1900s, the organization focused on such issues as protection of employed children, securing parent–teacher cooperation, child welfare, and children with disabilities. Today, the PTA has 6 million members working in 23,000 local units (PTA, n.d.).

Examples of locally based advocacy efforts abound. As parents and community members learn about poor school performance, achievement gaps among groups of students, and other issues, they often seek greater participation in decision-making and school governance. In Chicago, the School Reform Act of 1987 mandated local school councils, with parents forming the majority of members on each council. An organization of parents, Parents United for Responsible Education (PURE), was influential in passing that act and now offers training to parents who participate on the councils. PURE believes that its role is to hold the system accountable to parents. "School systems need pressure to reform, and parents must be prepared for the 'long haul' for real changes in the system to occur" (Lopez & Kreider, 2003, p. 3).

In many places, nonprofit organizations help parents develop the specific skills to participate meaningfully in school reform. In Kentucky, the Prichard Committee for Academic Excellence has an Institute for Parent Leadership, which helps parents learn to communicate effectively with each other and with school personnel about important educational issues to bring about change. The Boston Parent Organizing Network —a coalition of community-based organizations—plays a similar role in helping parents develop the confidence and skills to "take action around educational policy" (Lopez & Kreider, 2003, pp. 2–4). And in Swansea, a low-income Latino community in Denver, the local family support center played a key role in mobilizing parents who were adamant that their children, like the rest of the children in Denver, should not be bused out of the neighborhood to go to school. That inspiring story demonstrates the power of parent action to affect policy and practice at the grassroots level—and the importance of professionals to help them do so (see sidebar).

Parents also band together to make their communities safer and drug free. The Chippewa Neighborhood Association has been working with the local police department to get drug dealers out of its low-income St. Louis community. Association members see their task as creating a vision—and new hope—for their neighborhood. They have drafted a plan, raised money, implemented social services programs, and worked with homeowners and landlords to stabilize the neighborhood (Baum, 1999).

Public policies can encourage parent advocacy. Federal legislation, such as Head Start and the Individuals with Disabilities Education Act (IDEA), that recognizes the important role of parents in the lives of their children can go a long way to foster active parent participation. From its inception, Head Start was strongly committed to the

"maximum participation" of the families it serves. In 1989, in preparation for the 1990 reauthorization of Head Start, dozens of parents testified at a special hearing in Phoenix, Arizona, to tell their stories and express their views. A few months later, the president of the National Head Start Association, a former Head Start parent, testified before Congress. Over the years literally millions of parents have gained a sense of power and control over their lives by volunteering in Head Start classrooms, serving on policy councils, and being encouraged to speak up about their child's education, while in Head Start and as they transition into the public schools. Similarly, parents of infants and young children with special needs have been in the vanguard of parent advocacy efforts for 30 years and more. Parents have played a significant role in shaping federal and state early intervention policy and in implementing and monitoring intervention programs (see Berman & Oser, pp. 44–50, this issue).

We do not have to wait for laws to change to encourage parent action. Good infant–family practice can include opportunities for parents to become more actively engaged in issues affecting their children.

Policies to include parents are also emerging at the state level. One of the most successful aspects of the award-winning Smart Start Program in North Carolina is the involvement of parents in local planning for services for children from birth through age 5. In this way, efforts such as Smart Start are helping encourage the best that democracy can offer—citizen participation in the decisions that most affect their lives.

But we do not have to wait for laws to change to encourage parent action. Good practice in the fields of early childhood education, family support, and health care can include opportunities for parents to become more actively engaged in issues affecting their children. Parents often take their first steps in speaking out on behalf of children as they become involved in their child's early childhood program or help fill a gap in services in their community. Michael Cosby, a community leader in St. Louis who has been instrumental in working to improve neighborhood conditions, said,

Esfuerzos Unidos Succeeds in Denver

In 1997, the City Council of Denver passed a resolution that children would no longer be bused out of their neighborhood to attend school. In Swansea, however, the neighborhood's elementary school could accommodate only 460 of the 700 local children. So the city had decided that, unlike every other neighborhood, the children in this, one of the city's poorest communities where 98% of the residents were Spanish-speaking, would continue to be bused out.

The staff of Cross Community Coalition Family Resource Center heard a grumbling that built up to a roar, as parents coming to the family support center complained. Staff wanted to help, so they started asking parents questions during their bilingual parent groups: What's the problem? What would be a good solution? Who makes the decisions? As parents heard each other speak and gained strength in numbers, they formed an organization, *Esfuerzos Unidos*, which grew to 90 members. Parents wanted enough classrooms to keep their children in their own neighborhood—including adding to the elementary school and building a middle school (there was none). Staff of the program helped parents write a proposal, do outreach in the community to get signatures, and take their proposal to the school board.

The time came to present the proposal to the school board. A special meeting was called, to take place in the school auditorium. That afternoon, a blizzard covered the city in a foot of snow. Cross Community Coalition Family Resource Center Executive Director Lorraine Granado got frantic phone calls: Should we cancel the meeting? "No, we can't do that," she said. "Parents have leafleted every house in the neighborhood!"

The auditorium had a capacity of 100. That afternoon, parents streamed out into the hallways. With only one exception, every single school board member attended. They had arranged for simultaneous translation, planning to give the parents headphones, but there were so many parents, the school board members wore them instead! The principal, who had resisted the parents' proposal, stood before that crowd and claimed it as her own! The proposal passed by overwhelming majority.

Within 1 year, enough elementary school classrooms had been added to keep every child in the neighborhood. Within 3 years, a whole new middle school had been built, based on a plan created by parents. Based on the input of consultants brought in by Cross Community Coalition, the parents chose a design that divided the large school into three smaller schools of 250 students each. The seven parents on the naming committee, who were all Latino, called their school Bruce Randolph Middle School, after a local African American restaurant owner who was famous for donating food to thousands of poor people on Thanksgiving.

— Source: *National Family Support Story Bank, Family Support America*

My involvement started when my son was three-and-a-half years old and I went to a 'children's day' at Head Start, where I participated in class work with him. His teacher told me about the monthly parent meetings, which ultimately led me to the neighborhood improvement projects." (Cosby, 1999, p. 9)

Participation on small committees can lead to greater involvement in an array of issues affecting the quality of life for children and families in their communities and states. Parents who step forward to change the lunch menu at their local school, complain to the video store manager about the lack of appropriate movie choices for children, or work to secure better health care for their children can become strong voices in the policy arena.

Reviewing the parent organizing efforts that have been the most successful over the years, as well as some of the newer efforts that have emerged, we find several lessons to consider:

- Parents organize around specific issues or immediate problems.
- Parent action grows from the bottom up.
- Effective public policy promotes parent involvement.
- Good practice includes listening to parents and encouraging them to find their voice.

Supporting Parents as Advocates

Emphasizing the strength of bottom-up parent organizing does not preclude a role for professionals. As Anna Green, a parent leader in Spring Lake, North Carolina, said, "There is a role for the professional and also a role for families. They each bring their own strengths. If you build these strengths within the neighborhood, real change will happen" (cited in Baum, 1999, p. 28). In our daily work, we are aware that we may have significant knowledge and experience about child development in general, but parents are experts on their own children. It is this in-depth knowledge and understanding of their particular child that we respect and value—by listening to what parents tell us, by responding with services that are tailored to their needs, and by encouraging them to speak out on their own behalf. Similarly, as parents organize in communities around the country, our role is to combine our knowledge of community development and advocacy with their knowledge of their community and their family's needs, to work supportively with parents, and to let the parents lead.

Parent leadership training programs can serve as an important bridge to parent mobilization and advocacy. Since 1991, The Right Question Project in Cambridge, Massachusetts, has developed and taught parents a technique of formulating questions that can be applied to many kinds of issues and interactions with schools and social services systems. The Parent Leadership Training Institute, which has been part of Connecticut's Commission on Children for more than 10 years, has developed a "democracy curriculum" aimed at helping parents become

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civic leaders for children. Graduates mentor and support each other; they also serve on boards, design programs, organize in neighborhoods, run for elected office, or otherwise help guide state and local policy. In Chicago, the Community Organizing Around Family Issues (COFI) works from the principle that building stronger families also strengthens communities. COFI partners with local groups to provide parent leadership training that begins with articulating a vision and goals for the individual, then for the family, and then for the community, including encouraging participation. More than 1,000 low-income families have become successful advocates and leaders for themselves and their communities since 1994 through COFI's efforts. Parent leadership training programs help parents develop their skills to make their voice heard and become agents of change for issues that affect them and their children (Baum, 1999).

In the past decade, foundations and national organizations have been recognizing that long-term and substantial change for this country's most vulnerable children and families will necessitate a significant role for parents in programs in which they are a part. The Annie E. Casey Foundation's Making Connections Initiative is an ambitious 10-year attempt to model a new kind of partnership with the goal of strengthening families and transforming communities in 10 of the most impoverished urban neighborhoods in the United States. Resident leadership and local decisionmaking are central to this initiative, in which local leaders, residents, faith-based organizations, government, businesses, schools, and nonprofit community organizations work together to connect families to each other, to formal and informal social services, and to economic opportunities.

For the past 6 years, Family Support America (FSA) has been a national innovating force in nurturing and promoting parent engagement and leadership. The organization develops conceptual frameworks, training, conferences, and publications that describe and model shared leadership between professionals and parents. FSA efforts help local programs, state government systems, policymakers, and parents understand the importance of maintaining significant parent participation in all levels of decision-making and policy-making that affect children and families (Family Support America, n.d.).

Connecting the Dots in the Emerging Parent Movement

Parent voice is growing. Parents are mobilizing in communities across the United States to change conditions for themselves and their children. Professionals are assisting lay people in learning the language of policy and advocacy, of governance and decision-making. Policymakers and government officials, foundations, and national nonprofit organizations are realizing the importance of parents becoming involved in—and leading—efforts to change communities. Parent voices can ensure that public policy promotes rather than undermines family life.

The opportunity now exists to harness, capture, and coalesce the multiple state and local efforts into a strong national presence. A new wave of parent activism should include more fathers than in the past, as parent involvement moves to embrace fathers and mothers from diverse cultures and language groups. As the country ages, grandparents could become more involved. Organizations such as Generations United and AARP will play critical roles in supporting both grandparents caring for their own grandchildren and those older citizens who want to invest their time in improving the overall conditions in a community that supports children and families.

The promise and potential of unifying parent voices into a national parent voice that can wield the same kind of power and influence that senior citizens do through AARP remains an elusive but inspiring necessity. Many continue to dare to dream and articulate the vision of a national parent organization. Who knows how that dream will be realized and how the goal will be accomplished? As the digital divide narrows and the reach of the Internet expands, perhaps the unification of parent voice will occur virtually. Perhaps a national organization will emerge that has as its mission leveraging, celebrating, and highlighting local efforts.

A map of the United States today indicating where parents are organizing would have dots in local communities and in all states across the nation. When parents recognize the power they have and connect those dots, our country will be a far better place for children.

REFERENCES

Baum, S. (1999). Parent leadership training programs. *America's Family Support Magazine, 18*(1), 24–29.

Cosby, M. (1999). Changing our communities. *America's Family Support Magazine, 18*(1), 9–10.

Family Support America. (n.d.) Retrieved from www.familysupportamerica.org

Hewlett, S. A., & West, C. (1998). *The war against parents.* New York: Mariner Books.

Lombardi, J. (2003). *Time to care: Redesigning child care to promote education, support families, and build communities.* Philadelphia: Temple University Press.

Lopez, M. E., &Kreider, H. (2003). Beyond input: Achieving authentic participation in school reform. *The Evaluation Exchange, 9*(2), 2–3.

Minow, M., & Weissbourd, R. (1993, Winter). Social movements for children. *Daedalus: Journal of the American Academy of Arts and Sciences*, pp. 1–31.

Norton, D. G. (1994). Education for professionals in family support. In S. L. Kagan & B. Weissbourd (Eds.), *Putting families first: America's family support movement and the challenge of change* (pp. 401–440). San Francisco: Jossey-Bass.

Parent Voices. (n.d.). Retrieved on August 13, 2003, from www.parentvoices.org/accomp.htm

PTA. (n.d.). Retrieved on August 21, 2003, from www.pta.org/aboutpta/history/mile18890.asp and www.pta.org/indexc.asp

Skocpol, T. (1997). "Lessons from history: Building a movement for America's children" The Children's Partnership with Coalition of Community Foundations for Youth and The Johnson Foundation, 1997, Santa Monica, CA: The Children's Partnership; Kansas City, MO: Coalition of Community Foundations for Youth; Racine, WI: The Johnson Foundation.

Winnicott, D.W. (1964) *The child, the family and the outside world.* Harmondsorth: Penguin; Reading, Mass.: Addison-Wesley, 1987. As quoted in *WAIMH Handbook of Infant Mental Health, Vol. 1: Perspectives on Infant Mental Health*, Joy D. Osofsky with Hiram E. Fitzgerald, Wiley and Sons, Inc. pp.4–5

Winnicott, D. W. (1987). *The child, the family, and the outside world.* Reading, MA: Addison-Wesley. (Original work published 1964)

Zimmerman, E. (1993, November). Parents as leaders for children and policy. Unpublished remarks given at Child Care Conference, U.S. Department of Health and Human Services, Washington, DC.

Additional resources on parent advocacy:

Family Support America at www.familysupportamerica.org

National Parenting Association at www.parentsunite.org

September 11: Trauma and Human Bonds

(2003) Susan W. Coates, Jane L. Rosenthal, and Daniel S. Schechter, Editors (The Analytic Press, Inc., 101 West Street, Hillsdale, NJ 07642, www.analyticpress.com) $47.50. Hardcover.

Whether it is extraordinary trauma on an enormous scale, like that of September 11, 2001, or the traumatization of individual children and adults that clinicians treat in their everyday practice, the editors of this volume suggest that trauma must be understood in its relational and attachment context. ZERO TO THREE Graduate Fellow Daniel Schechter suggests that traumatically stressed caregivers are compelled to communicate their experiences of violence in an effort to regulate their own affect and physiology. Such parents skew the focus of joint attention to their traumatic experience(s) at the expense of mutual regulation and flexibility in the relationship with their young child. From brief interventions with traumatized children and families after September 11 at the Family Assistance Center in New York City, Coates, Schechter, and Elsa First observe that children's post-traumatic reactions seem to be inextricably tied up with the meanings that trauma, death, and loss have in their family system. The contributors to this volume stress the importance of secure attachment in childhood and mothers' reflective function as buffers against traumatization; they also describe brief and longer-term preventive and therapeutic strategies for children and adults.

Early Child Development in the 21st Century: Profiles of Current Research Initiatives

(2003) Jeanne Brooks-Gunn, Allison Sidle Fuligni, and Lisa J. Berlin, Editors (Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027) $29.95. Paperback.

The Synthesis and Profiles of Research Initiatives on Early Childhood Education and Development Project (The Profiles Project) was initiated to identify the current and ongoing large-scale research initiatives on early childhood education and development that are generating large data sets to help address myriad questions about the nature of development in diverse contexts and about the most effective ways to provide needed social and educational services to families with very young children with samples of at least 300 children and their families. Some studies are evaluations of large-scale intervention programs; others document the experiences of different populations of young children. Contributing authors follow a standard format, describing the history of the initiative, goals, current status, theory of change, design and methods, measures, units of analysis, results/findings, limitations, and the availability of the data for public access.

Among the initiatives described are the Comprehensive Child Development Program (CCDP); the Early Head Start (EHS) Research and Evaluation Project; Head Start Family and Child Experiences Survey (FACES); Nurse–Family Partnership; Healthy Families America (HFA); Healthy Steps (HS) for Young Children Program; Consortium for Longitudinal Studies in Child Abuse and Neglect (LONGSCAN); National Survey of Child and Adolescent Well-Being (NSCAW); National Institute of Child Health and Human Development (NICHD) Study of Early Child Care; Cost, Quality and Child Outcomes (CQO) Study; Welfare, Children and Families: A Three City Study; National Survey of America's Families (NSAF); Project on Human Development in Chicago Neighborhoods; National Early Intervention Longitudinal Study (NEILS); Early Childhood Longitudinal Study – Birth Cohort (ECLS-B); Fragile Families and Child Wellbeing Study; and Panel Study of Income Dynamics – Child Development Supplement (PSID-CDS).

The Clinical Interview of the Child (Third Edition)

(2003) Stanley I. Greenspan with Nancy Thorndike Greenspan (American Psychiatric Publishing, Inc., www.appi.org) $39.95. Paperback.

In this third edition of a work first published in 1981, Stanley Greenspan describes his developmental structuralist approach to observing the organization and content of behavior, as well as the developmental, individual-difference, relationship-based (DIR) approach to assessment and treatment. The book includes five accounts of assessment interviews with infants or very young children and their parents. Greenspan suggests seven principles for clinical work. Among these are: Always meet the child at his or her current level of functioning; always promote the child's self-sufficiency and assertiveness; and (remember that) affect and interaction are the basis for both ego development and intelligence.

The Boy Who Loved Windows: Opening the Heart and Mind of a Child Threatened With Autism

(2003) Patricia Stacey (A Merloyd Lawrence Book, Da Capo Press, Perseus Books Group, www.dacapopress.com) $25.00. Hardcover.

Patricia Stacey, a writer, college teacher, and former editorial staff member of the *Atlantic Monthly*, chronicles the first 5 years of her son Walker's life, beginning from moments after his birth in 1996, when she worried about his lack of crying and averted gaze. She describes Walker's severe

sensory integration and other difficulties and the family's experience in Massachusetts' early intervention system. When Walker was 8 months old, the director of the program gave Stacey copies of articles by Stanley Greenspan and Serena Wieder that had appeared in *Zero to Three* in October 1992. The family traveled from western Massachusetts to Bethesda, Maryland for a 3-hour assessment with Greenspan, who prescribed two sessions per week of sensory-based physical therapy and twice– weekly sessions of floor time with an educator; these were provided by the early intervention program. Also prescribed were 8 to 10 sessions a day of floor time with parents or others. Describing the years that followed, Stacey documents her (successful) advocacy for intensive services for Walker, the trade-offs involved in accepting a diagnosis of autism to avoid a reduction in services, the family's continuing relationship with Greenspan, and Walker's development into what Greenspan refers to as "a juicy kid."

VIDEOTAPES

As the Zero to Three *Journal's Assistant Editor for Videotapes, I am celebrating ZERO TO THREE's 25th Anniversary with a listing of videotapes that have been produced by ZERO TO THREE and members of its Board of Directors or that feature Board members. I welcome communications from readers about new videotapes of interest to the infant–family field.*

Margie Wagner
(cdmi@ix.netcom.com)

ZERO TO THREE

Learning & Growing Together With Families (2001)
Produced by and available from ZERO TO THREE, 2000 M Street, N.W., Washington, DC 20036-3307. Tel. 800-899-4301. Fax 202-638-0851. www.zerotothree.org. Purchase $69.00 plus shipping and handling.

The video package includes ***Seven Ways to Build Strong Relationships***, a 25-minute video with accompanying video guide, and ***Partnering With Parents to Support Young Children's Development***, a book by Jeree Pawl and Amy Dombro.

Designed for home visitors, Early Head Start staff, early intervention specialists, child-care providers, and others who work with the families of young children, the video training package teaches specific ways to build strong, collaborative relationships with families and with colleagues.

Seven Ways to Build Strong Relationships shows practitioners working with families in ways that promote the development of effective partnerships. The accompanying guide focuses on improving observation skills and relating the concepts presented in the video to one's own practice.

Partnering With Parents to Support Young Children's Development (also available separately) helps practitioners take a personal look at their work and the powerful impact they have on children and families.

Learning Through Observation (2002)
Produced by Claire Lerner and Lisa Zbar. Available from ZERO TO THREE, 2000 M Street, NW, Washington, DC 20036-3307. Tel. 800-899-4301. Fax 202-638-0851 www.zerotothree.org. 60 min. Purchase $64.95 plus shipping and handling.

This video was developed for supervisors, trainers, and program directors to use with front-line staff at all levels. The content areas include social–emotional development of very young children, working effectively with families, and developmentally appropriate practice in infant–toddler group care. The video provides non-narrated footage of real-life interactions between the staff of infant–family programs and families in a variety of situations. These include home visits in the context of Early Head Start, family support, and early intervention, and drop-off and pick-ups at child care. The user's guide will help a facilitator use the tape with trainees to refine general observation skills, explore the meaning of parent–child interactions, examine parent and staff interactions, consider options for balancing and or meeting the needs of both parent and child, and identify individual differences in children and families.

Kathryn E. Barnard

N-CAST– AVENUW Programs.
Produced by Kathryn E. Barnard. Available from N-CAST – AVENUW, University of Washington, Box 357920, CHDD Building, Room 100, Seattle, WA 98195-7920. Tel. 206-543-8528, fax 206-658-3284, www.ncast.org.

In 1971, Dr. Kathryn E. Barnard, scientific consultant to NCAST, initiated research that brought the ecology of early child development closer to the level of clinical practice by developing methods for assessing behaviors of children and parents. She identified environmental factors that are critical to a child's well-being and demonstrated the importance of parent-child interaction as a predictor of later cognitive and language development. Methods that she developed, widely known as the Feeding and Teaching Scales, were initially taught to over 600 nurses in 1979 in a series of 8 classes via satellite in the United States. NCAST became a self-sustaining organization, and the scales are now used in many settings and in research around the world.

Parent Child Interaction (PCI) Program. Includes instructional videotapes, manuals, scales, databases, and preview video. 1994 (Originally produced in 1979). Purchase $2000 Instructional videos; $15 Preview Tape; other prices available at www.ncast.org.

The Nursing Child Assessment Satellite Training (NCAST) Parent-Child Interaction (PCI) Feeding and Teaching Scales are the most widely used scales for measuring parent–child interaction today. Each scale contains a well-developed set of observable behaviors that describe the caregiver–child communication and interaction during either a feeding situation (birth to 12 months) or a teaching situation (birth to 36 months). Both scales are widely used in research and clinical practice and are valid tools for making reliable observations about dyadic interaction.

Keys to CaregivinG Program. Instructional videotape based program. 1990. Purchase $665 for the complete package.

The Keys to CaregivinG program is designed to teach about the competencies and capabilities of the newborn infant, their effect on caregiver–infant interaction, and ways to effectively translate this knowledge to parents. The program includes six instructional videotapes (Infant State, 33 min., Infant Behavior, 50 min., Infant Cues, 42 min., State Modulation, 39 min., Feeding Interaction, 62 min., and Nurse-Parent Communication, 55 min.), a facilitator's guide, a learner's study guide, and 5 parent handouts. The videotape provides visual examples of the behaviors described in the print materials. The study guide is designed to help organize learning and reinforce understanding of the video material. The individual parent handouts clarify and support the presentation of information to parents. The program was initially produced in the hospital setting, but it is appropriate for work with families in all pre- and postnatal settings.

T. Berry Brazelton

The Neonatal Behavioral Assessment Scale (NBAS) Videotapes. Produced by and available from Children's Hospital –The Brazelton Institute, 1295 Boylston Street, Suite 320, Boston, MA 02215. Tel. 355-4959 fax: 617-859-7215. www.brazelton-institute.com

The Neonatal Behavioral Assessment Scale (NBAS). 22 min. Purchase $52 plus shipping and handling. Also available in PAL.

This video shows Brazelton using the NBAS that, together with colleagues, he developed in 1974. The scale looks at a wide range of behaviors and represents a guide that helps parents, health care providers and researchers understand the newborn's language.

Using the NBAS with Infants and Their Families Video. 24 min. Purchase $52 plus shipping and handling. Also available in PAL.

Features J. Kevin Nugent using the NBAS with families.

Touchpoints. 3-Tape Set. 60 min. each tape. Produced by Pipher Films Inc. Available from Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. Fax 818-994-0153. Website: www.Child DevelopmentMedia.com. Purchase $80 plus shipping and handling.

T. Berry Brazelton defines "touchpoints" as the periods of time that precede a rapid growth in learning for both parent and child that are critical to future development. Twelve families are shown as they prepare for birth and experience the early years of their child's life. Volume I deals with key issues of pregnancy, delivery, and the first few weeks of life. Volume II takes on the practical issues of being a parent. Volume III deals with the more complex issues of 2- to 3-year-old children as they discover and exercise their independence.

Caring for Sick Children. 28 min. A Dartmouth-Hitchcock Medical Center production. Available from Films for the Humanities and Sciences, PO Box 2053, Princeton, NJ 08543-2053. Tel. 800-257-5126 Fax: 609-275-3767. www.films.com Purchase $89.95 VHS and $114.95 DVD plus shipping and handling.

In this program pediatricians T. Berry Brazelton and Stephen Kairys discuss the needs of sick children, how they differ from the needs of sick adults, and offer pointers for parents and caregivers.

The Changing Family and Its Implications: T. Berry Brazelton. 50 min. Available from Films for the Humanities and Sciences, PO Box 2053, Princeton, NJ 08543-2053. Tel. 800-257-5126 Fax: 609-275-3767. www.films.com Purchase $89.95 VHS and $114.95 DVD plus shipping and handling.

T. Berry Brazelton turns his attention to the problems and challenges of working parents. With Bill Moyers, Dr. Brazelton discusses the changing American family and its implications for our children.

Stanley I. Greenspan

Exploring First Feelings. 21 min., with accompanying book. 1990. Produced by the Institute for Mental Health Initiatives. Available from Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. Fax 818-994-0153. Website: www.ChildDevelopment-Media.com. Purchase $100 plus shipping and handling.

Using footage of parents and caregivers interacting with their young children, this tape illustrates milestones in the emotional development of infants and toddlers. Six overlapping stages of healthy emotional development are identified; a parent or caregiver is shown providing a supportive environment for each stage.

Floortime: Tuning into Each Child. 35 min. Available from Scholastic Inc., PO Box 7502, Jefferson City, MO 65120. Tel. 800/SCHOLASTIC. Fax 314-635-5881. www.scholastic.com. Purchase $74.95 plus shipping and handling.

In this staff training/parent orientation program, Stanley Greenspan shows how to "tune in" to the individual needs of children and how to help them develop emotionally, socially, and cognitively. The video, filmed in early childhood settings, is accompanied by a 48-page professional guide.

ICDL Training Videotapes on the DIR Model and Floor Time Techniques. Produced by and available from Interdisciplinary Council of Developmental and Learning Disorders (ICDL), 4938 Hampden Lane, Suite 229, Bethesda, MD 20814. Tel. 301.656.2667. www.icdl.com. Purchase $530 ICDL Members, $585 Non-Members.

This 13-tape series, nearly 20 hours in length, features Stanley Greenspan and Serena Wieder demonstrating the Developmental, Individual Difference, Relationship-Based (DIR) model and Floor Time strategies for different types of children and families with special needs. Each tape illustrates first-time sessions with parents playing with their child and how Floor Time coaching facilitates expanded interactions to support the child's developmental capacities to share attention, be engaged across a range of emotions, open and close increasing circles of communication, organize complex problem solving, create ideas and think logically and abstractly. Techniques utilizing affect cueing, playful obstruction, and symbolic challenges are demonstrated to achieve a continuous flow of spontaneous meaningful interactions. Included with the videotapes is a manual highlighting principles of intervention, what to look for in each of the tapes and a summary discussion of a comprehensive intervention program appropriate for the individual child.

Irving B. Harris

Right From the Start. 60 min. 1986. Produced by the Irving B. Harris Foundation. Available from Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. Fax 818-994-0153. Website: www.ChildDevelopmentMedia.com. Purchase $50 plus shipping and handling.

Exploring bonding and attachment between parents and infants, this videotape reviews the research of many scientists. Harry Harlow, Rene Spitz, and John Bowlby discuss the importance of attachment and bonding for normal development. John Kennell and Marshall Klaus identify the negative effect of early separation on family development. Selma Fraiberg demonstrates that deprivation of a nurturing mother or mother-substitute diminishes later capacity to commit to loving relationships and the human community. T. Berry Brazelton demonstrates how the early capabilities of infants and the balanced rhythm between infant and mother are essential to attachment.

J. Ronald Lally

The Program for Infant/Toddler Caregivers (PITC): A Relationship-Based Curriculum

Produced at WestED/PITC by J. Ronald Lally, Executive Producer, and P. L. Mangione, S. Signer, and G.O. Butterfield in collaboration with the California Department of Education. Available from California Department of Education, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271. Tel. 916-445-1260. Fax 916-323-0823. 800-995-4099 for credit card orders. www.pitc.org.

This 16-tape video-based curriculum with accompanying video magazines, guides, and manuals was produced to help caregivers recognize the crucial importance of giving tender, loving care and assisting in infants' intellectual development through an attentive reading of each child's cues. The curriculum has been designed to help child care managers and caregivers become sensitive to infants' cues, connect with their family and culture, and develop responsive, relationship-based care. Videos are available in English, Spanish, Chinese (Cantonese), and PAL (English) unless otherwise noted. Purchase $65 individual titles (unless otherwise noted); set prices available at www.pitc.org.

Among the tapes are:

First Moves: Welcoming a Child to a New Caregiving Setting. 27 min. 1988

Concepts developed from research and field experience are presented to help ease a child into a new child care setting by using time, space, and indirect contact and by reading the child's cues. The influence of the child's developmental level and the crucial role of the parent in the separation process are discussed.

Space to Grow: Creating a Child Care Environment for Infants and Toddlers. 22 min. 1988

The powerful influence of environments on infants and toddlers is described. Very young infants are limited in their ability to move away from an environment or to change it to their liking. The video demonstrates eight qualities for caregivers to consider when they are planning an environment for the care of infants and toddlers: health, safety, comfort, convenience, child size, flexibility, movement, and choice.

Getting In Tune: Creating Nurturing Relationships with Infants and Toddlers. 24 min. 1990

This video presents the importance of responsive caregiving and explores a process for getting in tune with infants and toddlers in a child care setting. The process consists of studying child development and temperamental differences in infants and toddlers; learning about the children's families and their cultures; developing self-awareness; and mastering the

responsive process of watch, ask, and adapt. Jeree Pawl and Magda Gerber are featured.

Flexible, Fearful, or Feisty: The Different Temperaments of Infants and Toddlers. 29 min. 1990

This video explores various temperament types of infants and toddlers identified in research studies by Stella Chess and Alexander Thomas. Techniques are described for dealing with children of different temperaments in infant/toddler groups. Alicia Lieberman is featured

The Ages of Infancy: Caring for Young, Mobile, and Older Infants. 26 min. 1990

This video identifies three stages of infancy, each characterized by its own developmental issue. For the young infant, security is the focus; for the mobile infant, it is exploration; for the older infant, it is the quest for identity. Specific guidelines and suggestions for caregiving are offered.

Discoveries of Infancy: Cognitive Development and Learning. 32 min. 1992

This video explores infants' and toddlers' constant quest for knowledge. It depicts six major kinds of discoveries children make in the first 3 years of life and offers guidelines on how to support early learning.

Together in Care: Meeting the Intimacy Needs of Infants and Toddlers in Groups. 30 min. 1992

During infancy children need deep connections with each person who cares for them, whether those persons are family members or caregivers. This video presents three child-care program policies that will lead to this special kind of care: primary caregiver assignments, use of small groups, and continuity of care.

Essential Connections: Ten Keys to Culturally Sensitive Child Care. 36 min. 1993

When young children are cared for by their parents and other family members, the process of cultural learning occurs naturally. Early child care that respects time-honored cultural rules helps children develop a secure sense of self. The video recommends 10 ways to structure and run child care programs to strengthen children's connections with their families and their home culture.

Protective Urges: Working with the Feelings of Parents and Caregivers. 27 min. 1996

In infant–toddler child care, caregivers have to provide emotional support to both the child and the parent. In this video parents speak candidly about their concerns, and caregivers discuss ways to provide assistance. The video shows how caregivers can come to better understand the behaviors of parents of infants in care, including highly emotional behavior and conflicting feelings about caregiver/child relationships. It also suggests how caregiver displays of competence, honesty, and understanding provide a base for family support.

Talking Points for Protective Urges: Video Clips for Group Discussion. 31 min. 1998. Available in English and PAL only. Purchase $20. ***Talking Points for Protective Urges*** contains four interview segments with Alicia Lieberman that did not appear in the original video, ***Protective Urges: Working with the Feelings of Parents and Caregivers***, and five segments from a discussion group with Lieberman and three caregivers.

Early Messages: Facilitating Language Development and Communication. 25 min. 1998

This video illustrates how infants' biologically built-in potential to learn language unfolds in the context of the child's family and culture. It suggests 10 strategies caregivers can use to enhance communication and language development.

The Next Step: Including the Infant in the Curriculum. 22 min. 2001. Available in English and PAL only. Purchase $19.

"This video is an attempt to encourage a view of the infant as a curious, motivated pre-programmed learner who is desperately in need of trusting and secure relationships as the base for both independent and interactive learning.

Alicia Lieberman

Mis Padres, Mis Maestras/My Parents, My Teachers Baby Kit. Produced by El Valor. Available from ZERO TO THREE, 2000 M Street, N.W., Washington, DC 20036-1013. Tel. 800-899-4301. Fax 202-638-0851. www.zerotothree.org. Spanish version 16 min. English version 17 min. Purchase $30 plus shipping and handling.

This bilingual video, featuring Alicia Lieberman, shows parents the importance of enriching children's experience from birth onward. The video shows families during everyday routines, feeding, bathing, and diapering as they talk, play, read, and sing to their babies.

Kyle Pruett

Begin with Love. 30min. Produced by and available from Civitas Initiative, 1327 West Washington Blvd., Suite 3D, Chicago, IL 60607. Tel 312-226-6700. Fax 312-226-6733. www.civitas.org. Purchase 16.95 plus shipping and handling.

This video, narrated by Oprah Winfrey, focuses on the relationships between a diverse group of parents and their newborn infants. Featuring Kyle Pruett, the video offers guidelines designed to help all new parents create a responsive and enriching environment for their young baby.

Young Minds: Is Zero-to-Three Destiny? 11 min. 1999. Available from Films for the Humanities and Sciences, PO Box 2053, Princeton, NJ 08543-2053. Tel. 800-257-5126 Fax: 609-275-3767. www.films.com

Purchase $69.95 VHS and $94.95 DVD plus shipping and handling.

This NewsHour program explores the heated debate over the developmental significance of the first 3 years of life. Skeptics include John Bruer, author of *The Myth of the First Three Years*, and Harvard child psychologist Jerome Kagan. Kyle Pruett argues in defense of the crucial importance of a child's early years.

On-Line Resources

The ZERO TO THREE Web Site

www.zerotothree.org

ZERO TO THREE's Web site began on a small scale in 1997, featuring a small selection of articles from the *Zero to Three* Journal and information on ZERO TO THREE initiatives. In its first year, the site received more than 650,000 hits. Currently the Web site receives nearly 2 million hits every *month*. The Web site's sections for professionals and parents have attracted a diverse audience. ZERO TO THREE is currently using the site to reach out to new audiences, including policymakers and the news media. Popular features include:

- *Brain Wonders*, a section on how the brain develops from birth to age 3;
- A growing list of Spanish language resources;
- Printable parent materials;
- A Tip of the Week feature for parents;
- Policy fact sheets and briefs;
- Two articles from each issue of the Zero to Three Journal;
- Access to professional education resources; and
- A new infant mental health page.

Docs for Tots

www.docsfortots.org

Docs For Tots is a nonprofit, nonpartisan advocacy organization, focused on very young children and their families. Executive Director George Askew, M.D., a graduate ZERO TO THREE Fellow, founded the organization.

The mission of Docs For Tots is to develop, support, and grow a nationwide network of doctors who respond to the requests of existing child advocacy organizations and others who request doctor participation in advocating for policies and practices that improve the well-being of our youngest children. The Docs for Tots Web site will feature an inventory of issue-specific talking points, presentations, and training and technical assistance materials.

The Urban Institute

http://www.urban.org/url.cfm?ID=410825

The Urban Institute is a nonprofit organization that publishes studies, reports, and books on topics that it considers timely and worthy of public consideration. The Institute's 2003 publication, *Improving Child Care Quality: A Comparison of Military and Civilian Approaches*, highlights the transformation of the U.S. Military Child Care System and compares it to several civilian models that are aiming at important reforms. The report is the latest in the Institute's "Charting Civil Society" series.

Family Support America

www.familysupportamerica.org

Family Support America is a 21-year-old national nonprofit resource organization for the theory, policy, and practice of family support. One feature of its Web site is the Learning Center, which features downloadable articles from *America's Family Support Magazine* on topics ranging from adoption to work-and-family issues. Also available on the site is *The State of Family Support: Seven-Year Gains from the Family Support America States Initiative*, supported by the Robert Wood Johnson Foundation.

The **Heller School for Social Policy and Management at Brandeis University** announces the availability of the **Frank and Theresa Caplan Endowed Fellowship** for September 2004. Full-tuition and a stipend will be awarded to an incoming doctoral student interested in early childhood policy. **Application deadline: December 15, 2003.** The Heller School doctoral program offers interdisciplinary training for people interested in social policy research with a concentration in children, youth, and families. For more information about any of Heller's degree programs, the Caplan Fellowship, or other funding programs, visit www.heller.brandeis.edu, or call the Heller school admissions office at (800)279 4105.

DEVELOPMENTAL MILESTONES

On April 30, 2003, **ZERO TO THREE celebrated its 25 years of work on behalf of babies and toddlers** with a celebration at The John F. Kennedy Center for the Performing Arts in Washington, DC. The event honored **Senator Patty Murray** (D, WA) and **Congressman Michael Castle** (R, DE) for their efforts on behalf of young children. Celebrities from politics, the media, and entertainment used song, dance, readings, and stories to convey the wonder of childhood and the joys of parenting and grandparenting. A "cast party" for performers and guests closed the evening. The event raised nearly $250,000 for ZERO TO THREE. **Carol Berman**, a member of the ZERO TO THREE Board of Directors, **Debbie Dingell, Sydney McNiff Ferguson**, and **Jane Abraham** served as co-chairs for the event. **Johnson & Johnson** was the presenting sponsor of this event. In addition, a number of other individuals and corporations provided support including, "platinum" sponsors **American Baby Group** and **The Coca-Cola Company**, and "gold" sponsors **Kaplan Early Learning Company** and **General Motors Foundation.**

In May 2001 ZERO TO THREE received a $1 million gift from **Philip and Lynn Straus** to initiate an endowment, ***The Fund for the Next Generation***, at ZERO TO THREE. The Strauses challenged ZERO TO THREE to raise an additional $1 million, which they pledged to match with a second gift of $1 million. In Spring 2003, we met the challenge. The $3 million *Fund for the Next Generation* continues to grow. The endowment was created to begin ensuring that ZERO TO THREE will have the capacity and resources in the future to strategically address critical and emerging needs of families with young children. *The Fund for the Next Generation* will give us the flexibility to strengthen and stabilize our operations so that we can continue to assist as many of our nation's infants, toddlers, and their families as possible—now and for generations to come.

The **US Department of Education** has awarded a 2-year grant to ZERO TO THREE and the **City of Alexandria, Virginia** for the **Language, Literacy, and Life (LLL)** initiative. **Alexandria's Office for Early Childhood Development, George Mason University**, and **Northern Virginia Community College**, together with ZERO TO THREE, will work with a selected group of approximately 110 early childhood directors, lead teachers, and assistant teachers, and family child care providers. They will participate in research-based and individualized training and professional development experiences that will include monthly seminars and intensive one-on-one on-site mentoring. The Project will also provide financial support for teachers and providers to pursue formal education, and recruit, train, and support community-based early literacy mentors.

The **Doris Duke Charitable Foundation** has awarded funding to ZERO TO THREE for a 3-year project to develop the capacity of Child Care Resource and Referral Agencies to offer training and support to child care professionals in building effective relationships with families, strengthening their service, and alleviating risk factors associated with child abuse and neglect. Over 3 years, we will work with training teams based in 60 Resource and Referral Agencies (R&Rs) in 12 states, utilizing in-person training, distance learning, and consultation.

The **Aetna Foundation** has awarded a grant to ZERO TO THREE for a new project, "Promoting Cultural Competency in Pediatric Residents: A model for training future clinicians to provide sensitive comprehensive health care to families of diverse backgrounds." This project will offer workshops, case-based discussions and individual mentoring to 90 pediatric residents currently training at Children's National Medical Center in Washington, DC. Residents will learn about the link between cultural barriers in patient-doctor communication and disparities in health outcomes, increase awareness of their own cultural practices and beliefs and how these affect their practices, and increase their own capacity to work with families to promote healthy development.

ERRATA

In the May 2003 issue of *Zero to Three*, Figures 1 and 2 on pages 59 and 61, in the article by Linda Perez and her colleagues ("Infant Mental Health Evaluation Process: Evaluating, Diagnosing, and Treating Infant Mental Health in Community Practice"), the right-hand column should be labeled "DSM-IV."

In the July issue of Zero to Three, the authors of "Every Child Counts: Creating a Community Holding Environment for Families With Young Children" (pp. 40–46) are Deborrah A. Bremond and Teddy Milder. Figure 3 on page 45 (Organizational Context of Relationship-Focused Work) was developed by the Children's Hospital Oakland Consultation and Training Team.

Upcoming Issues

November 2003 – Graduate Fellow Joy Browne is the guest editor of this issue, which examines **new perspectives on prematurity.** Articles will describe recent developments in research and clinical practice, mental health issues related to prematurity, dilemmas in the care of premature babies, lessons learned from long-term follow-up, developments in public policy, and the experiences of parents and other family members.

January 2004 – The contributors to this issue will describe **what babies can teach those who take the time to engage with them fully** — for example, that children under age 2 are funny, that babies and toddlers have very complex emotions, and that babies "cut through the cover of everydayness." We will also learn what a group of Navajo women see when they observe babies, and how infants and toddlers in the classroom prepare children for parenting. Contributors will include Betty Bardige, Eleni Louizu, Vasudevi Reddy, William Schafer, Colwyn Trevarthen, Deborah Weatherston, and Barbara Wightman, among others.

March 2004 – Dance movement psychotherapist Suzi Tortora is guest editor of this issue, which will explore **the role of somatic and nonverbally based early childhood experiences in the young child's development.** In addition to Tortora, who will write about nonverbal observation and movement-based intervention, contributors will include Beatrice Beebe, Theodore Gaensbauer, Myron Hofer, Janet Kestenberg-Amighi, and Stephen Porges.

The Editorial Mission of the *Zero to Three* Bulletin

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

The Mission of ZERO TO THREE: National Center for Infants, Toddlers, and Families

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional, and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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